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ABSTRACT

This casebook provides a reference and technical assistance tool for citizens and consumers with varying levels of knowledge or experience in the field of evaluation and monitoring, focusing on mental health centers. The purposes of this casebook and current knowledge about citizen evaluation are discussed. The 51 case summaries presented are grouped into these categories: (1) the evaluator's place in the mental health system; (2) extent of involvement of evaluators; (3) scope of coverage of evaluation; (4) focus of evaluation; and (5) procedures for evaluation. The format for case studies consists of a summary, type of organization evaluated, description of evaluators, reasons for evaluation, level of participation, target of evaluation, problems or issues evaluated, techniques used, findings of evaluation activities, recommendations, steps to ensure implementation, extent of implementation, special barriers to or support for evaluation, resources and costs, additional comments, and contact person. References and a glossary of terms are included. (ABL)

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citizen evaluation in practice

A Casebook on Citizen Evaluation of Mental Health and Other Services

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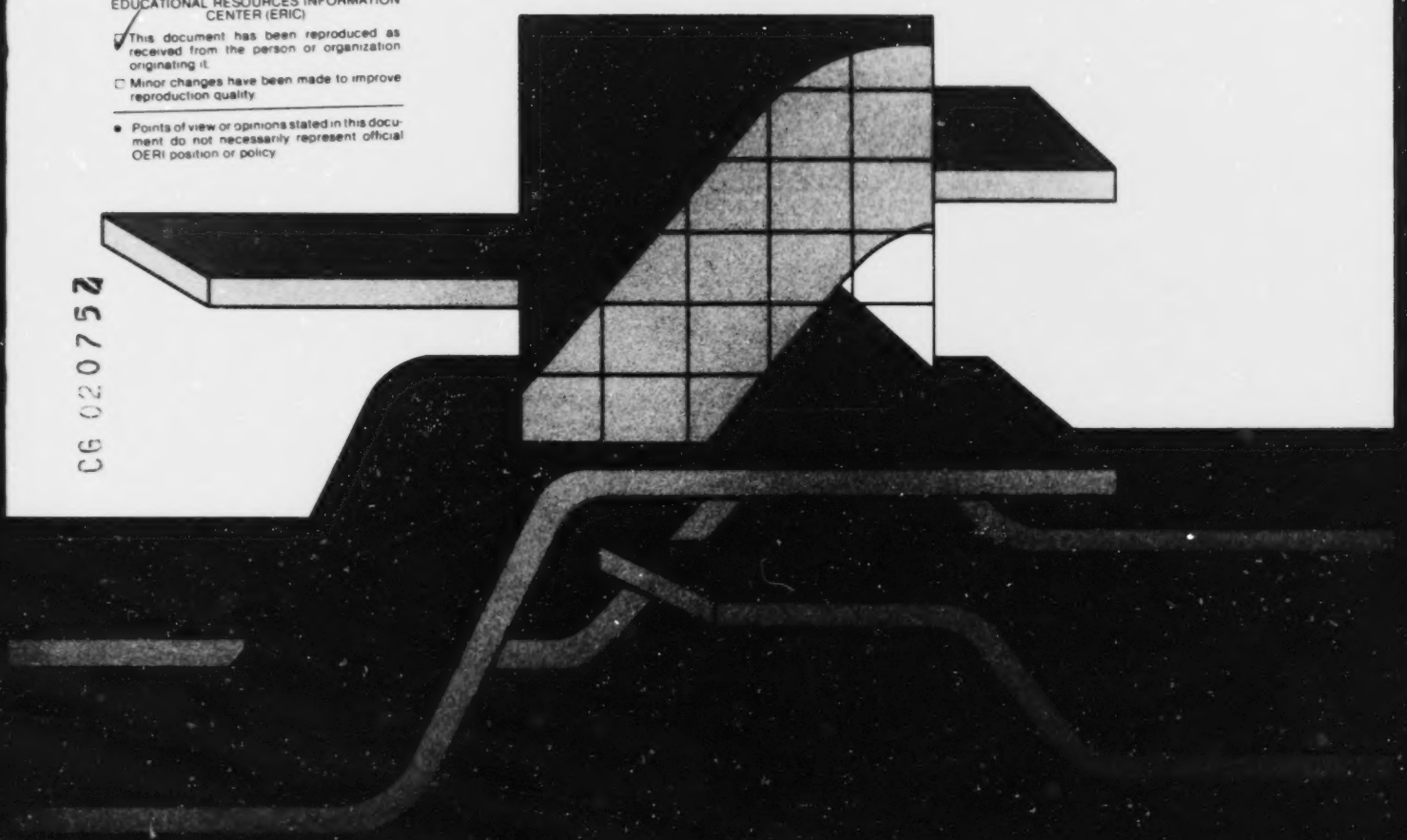

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Public Health Service
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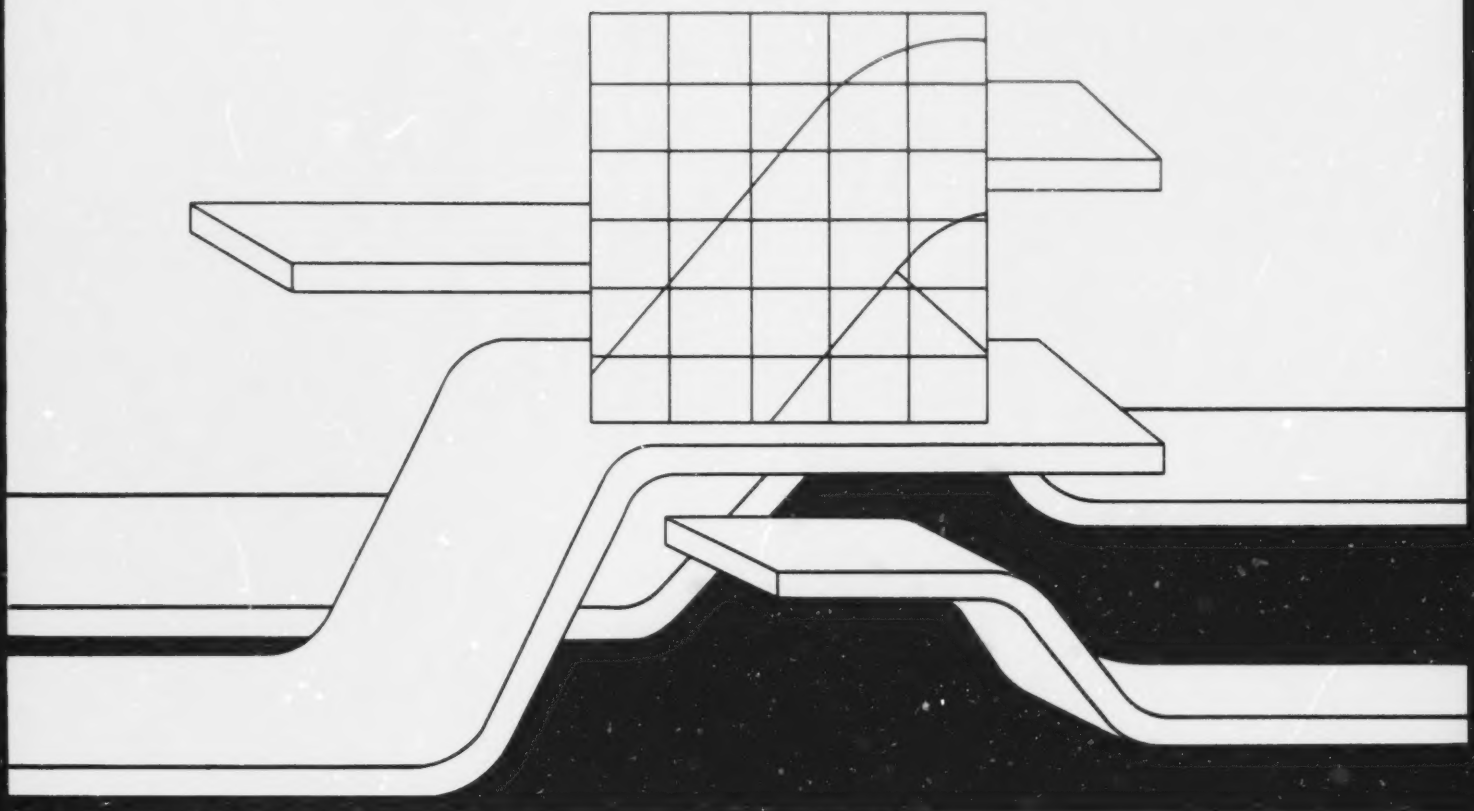
citizen evaluation in practice

A Casebook on Citizen Evaluation of Mental Health and Other Services



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Acknowledgments

This *Casebook* is a result of the extraordinary efforts of citizens from across the United States who, through perseverance and commitment, became involved in the evaluation and monitoring of mental health and other human service programs. Without the contributions of the more than 51 case authors, this *Casebook* would be a far less enriching and diverse document.

The planning and development of this *Casebook* was guided by the insights and comments of members of the project's advisory committee and NIMH project officers. These individuals represent a variety of viewpoints that mirror the range of citizen evaluation examples in the *Casebook*. They include the following:

- Marcia Buck, project administrator for a statewide mental health advisory organization that provides technical assistance and training to mental health volunteers.
- William Neigher, assistant director of a hospital-based community mental health center who has written extensively on evaluation from a practitioner's perspective.
- Lucille Kelly, a community mental health center board member who has participated in numerous evaluation activities.
- Vicky Rosan Hutter, a volunteer and office holder of a State mental health association.
- Joan Zinober, researcher and professional evaluator with specific expertise in citizen-based evaluation efforts.
- Charles Windle and Nancy Paschall of NIMH, who have directed and participated in many federally funded citizen evaluation projects and provided expertise during all phases of the project.

This publication was developed by Valerie J. Bradley, Mary Ann Allard, Virginia Mulkern and others from the Human Services Research Institute, Boston, Massachusetts, under contract number 278-81-0009 (MH) from the National Institute of Mental Health. Charles Windle, Ph.D., and Nancy Paschall, Ph.D., served as NIMH project officers.

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Foreword

Citizen evaluation represents a confluence of two movements: citizen participation and program evaluation. Citizen participation is a move to empower the public, and particularly the intended targets of programs, by providing opportunities for citizens and clients to guide programs toward their needs. Program evaluation is an effort to develop methods to study how well a program accomplishes what it is supposed to do. One goal of both these movements is to increase accountability of programs to the public and program funders. In citizen evaluation, lay citizens and consumers evaluate programs as one way to achieve the goal of program accountability.

The National Institute of Mental Health (NIMH) has supported both the citizen participation and program evaluation movements. In the Community Mental Health Centers (CMHC) program specific requirements in the Amendments of 1975 (Public Law 94-63) advanced the cause of citizen participation for residents of each CMHC catchment area in the governance of the local mental health center. CMHCs were also required to report their service statistics and to conduct program evaluations on designated topics. This law, furthermore, required each center to engage in citizen evaluation of a program review type, namely, each center

> will, in consultation with residents of its catchment area, review its program of services and the statistics and other [evaluative] information . . . to assure that its services are responsive to the needs of the residents of the catchment area.

NIMH has attempted to assist CMHCs and catchment area residents in carrying out these requirements in a variety of ways. Initial efforts focused on manuals (Hagedorn et al. 1976), resource materials (e.g., Hargreaves et al. 1977), and workshops for program evaluation specialists and administrators. Pertinent materials were produced for the various aspects of evaluation and quality assurance carried out by clinical peers (Hagedorn et al. 1976) and site visit monitoring by Government funding agencies (NIMH 1979). As CMHCs developed experience in program evaluation it became possible to produce casebooks (Landsberg et al. 1979; Gabbay and Windle 1975) that illustrate what some CMHCs have been able to do in practice. While these materials are of some help to lay citizen groups, material more specifically tailored to their backgrounds, perspectives, and purposes seems more useful. Several manuals have been developed to orient and guide citizen groups in program evaluation, some developed by NIMH (Peters et al. 1980), some by research groups with NIMH grants to work on citizen evaluation (Zinober and Dinkel 1981; MacMurray et al. 1976), and some by citizen groups themselves (Green and Matthews 1979; Mental Health Association 1976).

This *Casebook* builds on this sequence of technical assistance, moving from general manuals to specific cases by providing examples of how citizen groups have been able to put program evaluation into practice. The project to develop this *Casebook* was proposed by the NIMH Regional Office Task Force on Program Evaluation, endorsed by the National Council of Community Mental Health Centers and the Council on Research and Evaluation, and financed as part of NIMH's technical assistance to CMHCs. This *Casebook* was designed initially to parallel an earlier casebook, *Evaluation in Practice: A Sourcebook of Program Evaluation Studies from Mental Health Care Systems in the United States*

(Landsberg et al. 1979), but differences in the scope and approaches of citizen evaluations prompted considerable variation in the report outline. The present *Casebook* shows diversity in the forms of evaluations that citizen groups have attempted, variety in the methods used, and different results from these various experiences and approaches. What the collective and cumulative results of these experiences will be are in the process of being determined as citizen groups around the country reflect on their own experiences and on the experiences reported to them by others. The present *Casebook*, while not designed specifically to document representative evaluation experiences, can help citizen groups become aware of the breadth of evaluative activities in the late 1970s and early 1980s. The organization of the *Casebook*, which draws attention to the importance of using the evaluation results and clarifies other aspects of the evaluation process, will be especially helpful to citizen evaluators.

The Human Services Research Institute (HSRI) has done an excellent job in drawing on past NIMH projects and publications and HSRI's own past work with citizen and advocacy organizations and has been able to locate new cases varying widely in settings and approaches and to collaborate with these citizen evaluators in developing standardized but interesting descriptions of these experiences. The result is that this *Casebook* blends technical information and the sense of actually being in a program evaluation as citizen groups attempt to make improvements through this emerging mechanism. NIMH is pleased to have supported the development of this important work.

Lemuel Clark, M.D.
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Purpose of the Casebook

Objectives and Goals

The major objective of this *Casebook* is to provide a reference and technical assistance tool for citizens and consumers with varying levels of knowledge or experience in the field of evaluation and monitoring. For example, the *Casebook* should be as useful to the novice citizen evaluator who needs to understand the variety of approaches that are available in evaluation or monitoring as to the advanced citizen evaluator who may simply need additional techniques or implementation strategies. In order to meet this primary objective, the *Casebook* seeks to highlight the breadth and diversity of citizen and consumer evaluation and monitoring activities in mental health and other human services across the country.

More specific objectives include the following:

- To provide concrete examples of citizen participation in independent evaluations and in the review of agency mental health evaluation plans and results
- To differentiate evaluation activities according to the nature of citizen and consumer organizations (e.g., boards, free-standing entities, etc.), and their regulatory, statutory, and/or organizational purposes
- To display the multiple means available to citizens and consumers in program evaluation
- To organize citizen and consumer evaluation experience in a coherent fashion
- To prepare a document that challenges citizens and consumers to stretch their capabilities and "demystifies" the area of program evaluation
- To point out the ways in which program evaluation can be used to bring about service improvement and reform
- To illustrate certain pitfalls that may occur during the evaluation process and that should be avoided
- To show mental health administrators, as well as citizens and consumers, the positive benefits of citizen participation in program evaluation
- To encourage citizens and consumers to undertake the task of evaluation with a realistic appreciation of its feasibility, benefits, and difficulties

Finally, and most importantly, the *Casebook* will provide citizens and consumers with increased confidence in their capabilities and power to influence the shape and content of mental health services.

Preparing the Casebook

Project Conception

The community mental health movement contained concerns for program evaluation, citizen participation, and the combination of these procedures for program guidance and citizen evaluation. These concerns took the form of specific requirements in the Community Mental Health Center (CMHC) program (Public Law 94-63). During the implementation of the CMHC program, the National Institute of Mental Health (NIMH) followed a strategy of technical assistance in program evaluation that began by focusing on the development of manuals, orientation conferences, and training for CMHC professional staff. The second step was manuals for citizens and casebooks for professionals. The third step was casebooks and audiovisual orientation material for lay or citizen evaluators (several of these manuals are described in the introduction to the section, *What Do We Know About Citizen Evaluation and Monitoring*).

In order to address the specific needs and interests of citzens and consumers, NIMH staff commissioned a publication to illustrate the range of evaluation and monitoring activities that citizen groups can perform. The result is this *Casebook*, which can be seen as (1) a companion volume to NIMH's *Sourcebook of Program Evaluation Studies from Mental Health Care Systems in the United States* (Landsberg et al. 1979), hereafter called *Sourcebook*; and (2) a component of a larger body of information available to citizens and consumers. For instance, instead of repeating the various approaches to evaluation developed in another NIMH-sponsored publication *Citizen Roles in Community Mental Health Center Evaluation*, this *Casebook* shows citizens and consumers how these various approaches have

actually been applied in concrete situations. In addition, those readers who want more information on the numerous evaluation methods and instruments available in the field can refer to the *Sourcebook*. In other words, this *Casebook* is part of a sequence of technical assistance materials--the components of which are internally consistent in direction and useful in specific and unique ways.

Project Initiation

The development of the *Casebook* was aided greatly by NIMH project staff and members of the Project Advisory Committee composed of citizens, consumers, and professional evaluators. These two groups assisted HSRI staff in making key decisions regarding the types of citizen involvement to include in the *Casebook*, the definitions of evaluation and monitoring activities, the criteria to be used in selecting examples of citizen evaluation, and the methods by which such examples would be obtained.

In order to make the *Casebook* relevant to the widest possible audience and to encourage increased participation in evaluation by a broad range of individuals, the term "citizen involvement" is defined quite broadly. "Citizens" in this context are individuals who are external to the day-to-day operation of the system, agency, or program being evaluated, who may or may not have special expertise in evaluation research or mental health systems administration, and who are usually acting in a volunteer, unpaid capacity. "Involvement" in evaluation or monitoring covers every step in the process, from initiating an evaluation or monitoring program through developing recommendations based on in-house or professional evaluations and devising implementation strategies based on evaluation results.

Next, an overall definition of evaluation and monitoring had to be developed that encompassed pure evaluation activities (e.g., those with proven reliability and validity), as well as interesting and important examples that did not necessarily meet strict methodological tests. Hagedorn et al.'s (1976) definition captured this spirit:

> In its most basic form, evaluation is a *comparison* of actual program operations and results against a standard. The standard of comparison is usually data from similar programs or a judgment by an accepted authority or group on what should be expected.

With this as the core, the definition was expanded to include judgments by clients regarding agency performance and judgments based on norms--either ideological or professional.

Given this basic formula, certain activities were eliminated from consideration. For example, certain activities such as dissemination of information regarding center operations fell outside the definition of evaluation. Other efforts, such as the conduct of public forums to gain community input regarding service acceptability and accessibility, were incorporated within the definition.

Project staff and others also determined that the scope of the *Casebook* should be expanded to include monitoring activities. Monitoring is different from evaluation in that monitoring tends to be ongoing and involves observations and review of secondary data. Evaluation is more likely to be limited in duration and to involve the generation of primary data. These distinctions, however, are not hard and fast. Based on feedback from citizens and professionals involved in these activities, it became evident to project staff that monitoring bodies, such as judicially appointed compliance mechanisms and nursing home review groups, were performing activites that require techniques similar to those employed in evaluation. Likewise, monitoring has a related and usually positive influence on service quality.

In addition, specific criteria were developed to guide the selection of cases. The following list of criteria were applied to each case:

- *Transferability*--Does the example reflect efforts that can, with relative ease, be transferred to similar contexts?
- *Use of results*--Does the case represent activities of direct use in either improving an aspect of a mental health service facility or achieving general system improvement?
- *Practicality*--Does the case contain methods that are relatively easy to apply and that do not require substantial training, funding, or personnel resources?
- *Impact*--Does that case reflect some impact or outcome such as agency improvement, increased citizen interest, or reorientation of agency priorities?
- *Diversity*--Does the case contribute to a range of evaluation methods, settings, and auspices?
- *Validity*--Does the measurement process adequately represent the phenomenon being assessed?
- *Acceptability*--Does the case reflect techniques and goals that are generally acceptable and likely to be adopted by consumers, citizens, and ultimately policymakers and administrators?

In order to ensure that the citizen perspective was represented in the case descriptions, interested citizens or consumers were asked to write up cases where at all possible. In those instances

where this was not feasible, every effort was made to include at least some consumer or citizen involvement in the preparation of the case summary.

Finally, project staff of the Human Services Research Institute (HSRI) employed numerous techniques to solicit the case examples:

- A brief description of the project was prepared and sent to more than 35 national organizations and professional associations concerned with mental health or mental disabilities, including the National Council of Community Mental Health Centers, the Mental Health Association, and generic citizen groups such as the Center for Responsive Governance. At least 16 of these organizations included the project description in their association newsletters or other periodicals. The National Association of State Mental Health Program Directors sent the project description to each of the 50 State departments of mental health. This action alone yielded 31 responses.

- A direct mailing was sent to the respondents of the survey that was part of the citizen evaluation project that produced *A Trust of Evaluation* (described on page 10). These respondents were members of either mental health associations or community mental health center boards. Approximately 21 responses were obtained from this strategy. This mailing was conducted by Joan Zinober who also conducted the initial survey. In this way, confidentiality was not violated.

- A number of knowledgeable persons at the Federal, State, and local levels familiar with exemplary cases involving citizen evaluation were contacted. For example, a member of the Project Advisory Committee distributed the project description to the chairpersons of the 59 California County Mental Health Advisory Boards.

- Several reference materials secured from association newsletters also provided a certain number of potential cases for the *Casebook*.

HSRI staff received a total of 126 responses to the case solicitation and selected 93 as potential cases. They telephoned each potential respondent and followed up with a letter confirming his or her interest in participating in the *Casebook*. Specific materials explaining the format for the cases were also provided to authors.

The final *Casebook* contains 51 cases representing every region of the country, a variety of auspices and target groups, a multiplicity of methods, and a range of mental health-related issues. In order to capture the richness of each evaluation or monitoring experience, the case descriptions follow the same format and are organized to cover 16 categories of information. These categories are described in the format for case description sent to all case authors (see box).

How to Use the Casebook

The *Casebook* has been designed to present information in a manner that is easy to understand and may stimulate further interest in citizen evaluation and monitoring.

After considering several different ways of organizing the material, HSRI staff--in consultation with NIMH and the Project Advisory Committee--decided to present the cases in six major chapters that focus on organizational context, role, scope, topic, method, and techniques for implementing findings. The chapters follow the logical sequence of steps that a citizen or consumer should take to initiate and carry out an evaluation or monitoring task. The specific content of the chapters is outlined below.

- *Organizational Context--Where Are You in the System?*

  In this section, citizens will learn how to examine their position in the larger scheme of things. The need to understand where a citizen group fits in the system as well as what rights and responsibilities it has is an important first step. The cases in this chapter show citizens functioning in a variety of settings ranging from State mental health advisory boards to boards of local agencies. These cases should help the reader to determine his or her own position in the system and the implications that this position has for the design of an evaluation or monitoring activity.

- *Role--How Much Will You Be Involved?*

  This chapter addresses the importance of making a realistic appraisal of the level of commitment that can be expected from each member and from the group as a whole. This appraisal, coupled with the organizational concerns in the chapter above, will determine how active a role the individual or group will play. Cases in this chapter show citizens and consumers taking on a range of roles including simply reacting to the results of evaluations conducted by others to conducting full-scale independent evaluations.

- *Scope: How Far Will You Cast the Net?*

  Evaluation and monitoring activities can focus on a range of targets from very broad to

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Format for Case Descriptions

Summary	Please provide a brief overview of the evaluation or monitoring activity in order to introduce the reader to your experiences.
Type of Organization	Please tell us what type of group or organization conducted the evaluation or monitoring activity. Was it a community mental health center board? A State mental health advisory board? An advocacy organization? Also, please include any other relevant information on the organization including such things as how it is constituted, how many members it has, who appoints the members, and what the formal responsibilities of the group are.
Evaluators or Monitors	Please tell us something about the individuals who carried out the project. Were they professionals, lay persons, consumers, civic leaders, or a combination of individuals?
Reasons for Evaluation or Monitoring	Please tell us what prompted the evaluation or monitoring activity? Is it mandated by State law? Was a particular problem brought to the attention of your organization? Are you part of an ongoing monitoring activity?
Level of Participation	Please tell us how involved you were in the evaluation or monitoring activity. There are several forms that your participation may have taken. You may have been asked by an agency to provide information. You may have reviewed information prepared by a service agency or service system. You may have joined together with an agency to conduct an evaluation or you may have conducted an evaluation that was totally independent of the service system.
Target of Evaluation or Monitoring	Please tell us about the agency or program which you assessed. We need to know two things. First, how broad was the study—did it encompass a whole State, a county or regional system, a comprehensive agency, one aspect of a program, or a cluster of programs? Second, what type of agency or program is being evaluated? In responding to the second point, please let us know the name of the agency or agencies, the type of community in which it is located, the nature of its administrative structure and any other pertinent information about the entity that you feel is relevant.
Problems or Issues Evaluated or Monitored	Here, we are interested in learning about the nature of the issues or problem which you or your group addressed during the evaluation or monitoring activity. For instance, were you concerned about the needs of special groups such as the elderly or children? Were you primarily interested in the way the program carried out its administrative responsibilities, or were you more interested in the physical plant? Were individual rights of clients a prime focus or did you focus more generally on service quality?
Techniques Used	Please discuss the types of techniques or methods you used to gather information for your evaluation or monitoring activity. Techniques might include such things as site visits, public forums, community surveys, consumer satisfaction questionnaires, or facility check-lists. Please let us know how the techniques were selected, who participated in the design of the study, and whether the techniques proved useful.
Findings of Evaluation or Monitoring Activities	Please tell us what you found out as a result of the evaluation or monitoring project. For instance, did you find that services were adequate or inadequate? Is more funding required? Are there certain administrative practices that should be changed or improved? Is there a particular segment of the program's potential client group that is not being served?
Recommendations	Based on the findings which you have described above, what did you or your group recommend as ways of improving the program or programs you assessed? If the program or agency was performing adequately, then let us know what kinds of comments you included in your final report. Please also let us know to whom the recommendations were directed (e.g., the agency director, the State legislature, the State department of mental health, etc.).
Steps to Ensure Implementation	Where your recommendations called for some specific change or activity, we are interested in how you went about making sure that these recommendations were actually implemented. Did you publish your recommendations in the paper? Did you make a presentation to your legislature? Did you use the leverage or legal authority of your organization to enforce change?
Extent of Implementation	We are interested in the results of your efforts to secure change or improvement in the programs or agency you addressed. Were any or all of your recommendations implemented? If not, why not?
Special Barriers to or Supports for the Evaluation	Looking back on your experiences, were there any particular constraints that limited your ability to carry out the evaluation or monitoring activity? For instance, did you have problems with the technique you used? Were there political problems that hampered your efforts? Was it difficult to secure sufficient time from volunteers to complete the effort? We are also interested in a description of those things that assisted you in your assessment such as a supportive board of supervisors, a dedicated group of citizen volunteers, or a particularly effective method.
Resources and Costs	Please tell us the amount of personnel (staff and volunteer) time needed to complete the evaluation or monitoring activity. If feasible, please provide costs for any paid staff. It would also be interesting to know how you or your group obtained the resources necessary to carry out the project.
Additional Comments	Please tell us any further thoughts you may have on your experience. For instance, would you do it the same way next time? How would you change the process? What lessons would you like to share with others in the same circumstances?
Contact Person	Please list the name, address and phone number of a person familiar with the case who will be available in the future to answer any questions. This person may be you or anyone you feel would be appropriate as a continuing reference.

extremely narrow. One of the earliest decisions that groups have to make is the scope of their inquiries. This chapter includes cases in which citizens evaluated everything from an entire system to one component of one agency's program. The cases have been selected to help the reader understand the importance of keeping the scope of the evaluation consistent with the group's authority and resources.

- *Topic--What Will Be Your Focus?*

  This chapter will help citizens and consumers select the issues on which to focus. The cases reflect the multiplicity of topics that citizen groups around the country have assessed, including client rights, administrative practices, facilities, and institutional closure. These cases should help the reader to select topics that are consistent with the mission, resources, and authority of the citizen or consumer group.

- *Method--How Will You Go About It?*

  This chapter reviews the various evaluation and monitoring methods that can be used by citizen and consumer organizations. Cases in this chapter show citizens applying techniques as varied as site visits, client interviews, key informant interviews, surveys, and observation. The examples should help the reader to match the area to be explored with the most useful means of collecting information about that topic.

- *Implementation--How Will the Results Be Used?*

  Evaluation or monitoring alone cannot bring about change. The results have to reach the right hands and must be presented in a form that is readily understandable. The importance of formulating a plan for circulating the results, bringing the issues to the public's attention, and following up on recommendations is highlighted by a review of selected cases from previous chapters.

- *Summary*

  This final chapter provides a brief overview of the lessons learned from the range of experiences presented in the cases.

In order to clarify these steps and to provide continuity for the reader from chapter to chapter, a hypothetical or idealized case involving a citizen evaluator, Doug Brown, has been designed. Each chapter begins with the next phase of Doug's deliberations as he and his planning and evaluation committee grapple with key evaluation options and considerations.

The 51 cases in the *Casebook* have been organized under six chapter headings. It should be noted, however, that the cases reflect concerns beyond the issues raised in any single chapter. This cross-reference index has been compiled so that the reader can focus not only on one particular aspect of the case but can also, through the cross-referencing system, determine how it fits into the other *Casebook* categories.

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What Do We Know About Citizen Evaluation and Monitoring?

Introduction

Citizen evaluation and monitoring in the field of human services generally and mental health specifically are relatively new phenomena. Citizen interest in program oversight has evolved in response to several pressures and issues: (1) a growing skepticism of Government's and others' abilities to provide responsive and efficient services; (2) a basic recognition in the United States of the value of citizens' ideas; (3) an impetus to eliminate waste, increase efficiency, and ensure accountability; (4) a plethora of court cases addressing both human rights and client rights that directly involve consumers in evaluation of service effectiveness; (5) use of citizens by public agencies to monitor publicly funded programs that resist government oversight; and (6) involvement of citizens and consumers in order to develop support for difficult and controversial decisions (Dinkel et al. 1982).

The inclusion of citizens in mental health evaluation can be attributed more specifically to Federal mandates requiring such participation in the CMHC program. The recent enactment of block grant legislation (Public Law 97-35), however, has removed the Federal statutory requirement for citizen evaluation of CMHCs. Despite this change, citizen evaluation appears to be well established as evidenced by the variety of examples that can be found in the literature, and that were solicited for the *Casebook*.

For the most part, what we know about citizen evaluation and monitoring can be found in a small but developing selection of theoretical and research studies and a somewhat larger collection of "how-to-do-it," or technical assistance materials such as guides and manuals.

In order to give the reader the flavor of what has been written on citizen evaluation and monitoring as a backdrop for the Casebook, the following two-part review of materials is presented. The first section describes the evolution of citizen evaluation and monitoring in generic services and in mental disabilities, and the second section briefly summarizes the materials that are available to citizens to assist them in implementing evaluation or monitoring strategies.

Evolution of Citizen Evaluation and Monitoring

Citizen Participation in Social and Economic Programs

The antecedents of citizen evaluation and monitoring can be found in the citizen participation movement that began in the 1960s and included such concepts as "maximum feasible participation of the poor" and "community control." The initiation of the Great Society programs and their concomitant requirements for citizen participation spurred the development of numerous articles and books that describe the potential and limitations of citizen involvement in neighborhood development, urban renewal, health planning, education, and other areas (Brody 1970; Marshall 1977; Piven 1966; Slaver 1970).

Community participation in federally funded programs was the forerunner of other related citizen review activities including advocacy research, consumerism, and the self-help movement. Various studies concerning either citizen participation or its off-shoots, such as consumerism, describe the level of influence or power that citizens can obtain, the ways in which citizen participation can be effective, and the limitations of increased citizen participation in decision-making. Certain authors have suggested various classifications, such as the citizen participation ladder that arrays citizen boards on a continuum from purely advisory at one end to citizen control at the other end (Arnstein 1969). Others have developed strategies of citizen participation including staff supplement, cooptation, advocacy, and community power (Burke 1979). Many studies, however, simply describe and compare the use of citizen boards or other participatory mechanisms to influence public policy (Mogulof 1969; Vanecko 1969).

Citizen Participation in Mental Health

As one observer notes, "while there have been numerous studies of the participation of the poor

in a wide variety of programs, citizen participation in mental health programs has not generally received the same degree of attention" (McCord 1982). This same author goes on to suggest that this disparity in the literature should not exist since mental health associations and state hospital boards of visitors involve a tradition of citizen participation in mental health programs that substantially predates recent developments in other programs.

Some studies in this area highlight the early barriers to citizen involvement in the CMHC program. For instance, an analysis reported in 1974 notes the lack of emphasis on citizen participation in the early stages of the CMHC program, especially the lack of legal authority of citizen advisory boards (Chu and Trotter 1974). Another observer cites the initial difficulty of defining "community" and, consequently, the role of citizens and consumers in planning and operating community mental health services (National Institute of Mental Health, undated).

Several studies that examine citizen participation in mental health have focused on the problems encountered by volunteers, especially lack of power and effectiveness in their roles. For example, a 1974 study of the perceptions of community mental health center board members in the State of Tennessee revealed that half the respondents thought that their actual power to influence was quite limited (Robins and Blackburn 1974). Other studies have identified problems common to citizen boards including role confusion, lack of staff support, and lack of responsibility for decisionmaking (Morrison et al. 1978). At the same time, certain observers noted that citizen participation in mental health services must be tempered by political realities and adapted to express community needs and goals (Kane 1975).

More recently, a study of mental health center boards in New York and Pennsylvania examined the division of responsibilities between boards and program directors. The author suggests that despite a lack of clear, formal differentiation of responsibilities between boards and program directors, there was little conflict since boards do not seek to expand their influence but generally defer responsibility for most tasks and decisions to agency directors (McCord 1982). In another study of area mental health boards in Massachusetts, the authors found that four types of board accomplishment--service creation and improvement, outside resource mobilization, local autonomy, and coordination--were positively influenced by organizational characteristics and attitudinal variables (Dorwart and Meyers 1981).

Despite the limitations of citizen participation in mental health programs, the importance and value of such input has been reaffirmed in most studies, and as suggested in the Massachusetts area board study, citizen participation has been extended to include new dimensions such as review and evaluation of mental health center programs.

Development of Citizen Evaluation and Monitoring in Generic Services

It is not surprising that citizen participation expanded into the areas of monitoring and evaluation of publicly financed programs. A major impetus for this was the decentralization of many Federal grants programs (e.g., General Revenue Sharing, Community Development Block Grants, Comprehensive Employment Training Assistance, etc.) and the Federal requirements that citizens should be involved in the evaluation of local programs. Citizen evaluation and monitoring has also encompassed nursing homes, schools, biomedical developments, and environmental issues.

The expansion of citizen evaluation and monitoring in such disparate areas as community development and biomedical innovation was influenced by the need for greater public accountability in these complex programs. Equally important was a general dissatisfaction with the usefulness of evaluation research and the absence, very often, of those persons most affected by the program in the evaluation activity. With respect to the latter criticism, Federal agencies such as the National Institute of Education introduced the "stakeholder" approach to evaluation in an effort to include a broad spectrum of users and consumers in the evaluation activity. More recently, researchers have criticized this approach as it was applied in certain federally funded evaluations (Bryk 1983).

Citizens have taken a more proactive role in evaluating local school programs. The National Committee for Citizens in Education (NCCE), a nonprofit public interest organization, has prepared numerous documents to assist parents and others to evaluate local schools. For example, the author of one document describes the characteristics of what is generally believed to be a good school and the ways that citizens can establish their own standards for determining the quality of the education their children receive (NCCE 1982).

The importance of community participation in evaluation activities is discussed by several observers within the context of a successful community development effort in a rural Missouri community. The authors of this study suggest that participatory evaluation can increase the community's knowledge of itself, what it accomplished and what it failed to do. Moreover, the results of the evaluation reflect those areas in which the community has the greatest interest and are presented in lay terms, not professional jargon (Lackey et al. 1981).

Citizen participation in community development decisions would seem to be a logical role, given the publicly oriented focus of the program. Such involvement, however, in highly technical

and scientific areas is not as easily accepted. One observer suggests that the general public has the ability to participate in complex technical areas and discusses those efforts in the context of four controversial medical innovations: DES (the morning-after pill), the artificial heart program, the swine flu immunization program, and recombinant DNA research. As noted by the author, three themes concerning the way in which lay citizens influenced these controversial areas recur in all four efforts:

> . . . reassessing risks and benefits; broadening and humanizing the perspective taken on issues; and trying to assure sound and legitimate decisions through a more democratic decision process (Dutton 1982).

Citizen monitoring examples are also prevalent in generic services. As noted earlier, decentralization of Federal grants programs spawned several national citizen monitoring efforts that were organized around local grassroots coalitions. As one observer notes, perhaps the most comprehensive citizen monitoring project to date has been the assessment of Community Development Block Grants (CDBG) conducted by a coalition called the Working Group for Community Development Reform (Eisenberg 1981). Financed through a Title IX grant from the Community Services Administration, national staff developed a research design and a set of survey forms that were used by all participating local groups to monitor and evaluate the CDBG program. Since the monitoring project began, two major documents have been produced that demonstrate the significance of citizen monitoring as a local and national resource, as well as the inadequacies of the CDBG program (Center for Community Change 1980).

Citizen monitoring efforts in children's services, nursing homes and Federal programs (Medicaid, Title XX, etc.) have also been documented. For example, since 1974, the Community Council of New York has conducted more than 15 monitoring projects of publicly funded social service programs and experimented with a variety of approaches, including the use of journalism students to monitor a new income maintenance program (Community Council of Greater New York 1979). In another example, the Massachusetts Office for Children established an institutional review committee that grew out of its statewide network for citizen participation. As stated by the authors of a handbook on citizen review,

> institutional review by citizens is not just another agency evaluation or licensing visit . . . [it's] people who believe in their community's responsibility for its children (Goldman et al. 1980).

And finally, increasing public concern regarding the quality of care provided to nursing home residents has prompted several documents exploring the use of volunteers to evaluate or monitor nursing homes (Durman et al. 1979).

Much of what has been written on citizen evaluation or monitoring describes traditional, and fairly straightforward, approaches. Certain system observers, however, would include nontraditional approaches such as legal and journalistic models (investigative reporting) among those methods that could be used to evaluate or monitor public activity. According to these authors, legal and journalistic approaches emanate from a humanistic rather than a "rational service tradition," and both are case oriented (Levine 1982). This same system observer would also include whistleblowers and individual efforts such as Lois Gibb's investigation of the health effects of toxic chemicals in Love Canal under the heading of citizen evaluation and monitoring.

In all of the approaches described in the literature--both traditional and nontraditional--a major theme that emerges is the difference in approach between lay or volunteer evaluators/monitors and professionally directed program reviews. Observers in the mental health field have looked at these differences in formulating a conceptualization of citizen evaluation and monitoring.

Citizen Evaluation and Monitoring in Mental Health Services

Since the enactment of the 1975 Amendments to the Community Mental Health Centers Act (Public Law 94-63) requiring citizen review of center services, several reports have been prepared that examine the implementation of that requirement, as well as general citizen involvement in mental health evaluation and monitoring. As noted by some authors, the significant dimension of citizen evaluation is the participants' roles and concomitantly the amount of influence or power they can exert in those roles. Similar to the classifications developed in the late 1960s with respect to citizen participation, several researchers have developed a classification of citizen roles in evaluation--ranging from the most passive (i.e., subjects of evaluation and recipients of information) to the most active (i.e., partners in evaluation or independent evaluators) (Dinkel et al. 1982). These roles are then analyzed by the type of potential participant involved (consumer, community, program employee) and the specific evaluation functions they might perform.

One role in particular, the solicited reactors to evaluation, was mandated by the 1975 Amendments to the CMHC Act and led to further research and ultimately the development of a mechanism known as the citizen review group (CRG). The CRG process varies in who assumes primary responsibility (evaluation staff, agency

board, or external citizen group) and is a relatively undemanding form of citizen participation in evaluation (Zinober et al. 1980).

These and other studies reveal that for the most part CMHCs have not sought out the public--other than their own boards--in evaluation activities (Flaherty and Olsen 1982). Even CMHC boards, according to some observers, have shied away from active participation in evaluation activities. In a recent study of center boards in New York and Pennsylvania (McCord 1982a), three of the five boards analyzed indicated that agency review and evaluation was primarily a responsibility of the agency director. As noted by the author, board members were more willing to assume or accept responsibility in areas that appeared less "technical," such as where to locate agency facilities. In general, boards are uncertain as to how to evaluate a program's performance, or what criteria or standards to utilize--questions that plague professional evaluators as well (McCord 1982b).

One important form of evaluative information is consumers' satisfaction. In a review of existing studies, Lebow (1982) observed that assessment of consumer satisfaction with mental health services was unusual 15 years ago, but today such surveys are standard parts of the practice of many mental health facilities, especially community mental health centers. It should be noted, however, that since this type of evaluation is no longer required of CMHCs, its importance may diminish. Since there is a large but unorganized body of literature on this subject, readers who are interested in pursuing consumer satisfaction in more detail should first explore the literature reviews that are available. Although certain drawbacks to consumer evaluation have been documented, some evaluators have stressed its importance in making programs more responsive and, in effect, protecting consumers from potential problem situations (Quilitch and Szczepaniak 1976).

Recently, consumer evaluation has involved nontraditional subjects such as children and their families participating in treatment planning conferences and the review of such conferences (Favaro and Love 1983). Parents often differ from professionals in what they expect from services and evaluate services from a different vantage point (Sommers and NYCA 1979).

Some of the major differences in lay and professional evaluations have been described by various system observers. For example, authors have suggested that findings from citizen evaluations are more useful because (1) citizens have greater access than professional evaluators do to implementation strategies (e.g., contacts with the legislature and the media) and (2) the community ultimately inherits the results of the evaluation, rather than the professional evaluator or program administrators who may be personally less committed to certain types of program changes (Windle 1976). Other differences include the lay evaluator's use of common sense rather than theories for guidance and values that counter the elitist domination of professional evaluation and democraticize program administration. In addition, using citizens to perform certain evaluation tasks leaves the professional evaluators free to focus on those areas where their skills and contributions are unique. Finally, citizen evaluators can also help public agencies save limited funds (Windle 1976).

There are, however, drawbacks to using citizen evaluators. As noted earlier, many of the limitations of lay evaluation or monitoring can be attributed to the role that citizens play in such activities. For example, some observers have found that lay citizen groups seldom function as completely independent evaluators but are most likely to evaluate in cooperation with agency staff (Zinober et al. in press). Thus, citizens outside of the agency being evaluated are often limited in what they can learn. A second drawback may be that many lay citizens have a strong interest in service expansion since they will be either directly or indirectly affected by the results of the evaluation. Moreover, the extent to which lay evaluators actually represent the larger community, as in other citizen-directed activities, remains a problem. Also, citizens, like professional evaluators, will bring their own biases to the evaluation; however, such biases can be minimized through training and exposure to a broad range of ideas (Hessler and Walters 1976).

This last point does suggest that in some respects citizen evaluators are similar to professionals. Perhaps what is most unique about citizen evaluation or monitoring is that it provides an outsider's view of the system. What is often lacking for many potential citizen evaluators or monitors is the necessary tools, training, and exposure to evaluation methods. The final section of this literature review briefly describes what is available to assist consumers and other citizens in the performance of evaluation and monitoring.

Technical Assistance for Citizen Evaluation and Monitoring

Traditionally, materials on program evaluation have been relatively technical, but recently a number of manuals and monographs on mental health evaluation in general and citizen involvement in evaluation in particular have been published.

In *A Trust of Evaluation: A Guide for Involving Citizens in Community Mental Health Center Evaluation* (Zinober and Dinkel 1981), the authors describe a project in which 17 CRGs were set up to review the evaluation reports of seven community mental health centers. This monograph is useful for citizens desiring to become involved in evaluation. It covers such areas as CRG membership, recruiting, group dynamics, and the flow of

information between the center and the citizen group.

A second monograph, *Citizen Roles in Community Mental Health Center Evaluation: A Guide for Citizens* (Peters et al. 1979), describes the way in which citizens can use evaluation to regain some control over agencies that serve their communities. The monograph starts by explaining the evaluation process in laymen's terms and describes a variety of activities that can be performed by citizen groups, including preparing information about the center, reviewing the center's plans for evaluation, and conducting simple evaluation studies. Examples of relatively simple studies such as surveys of consumer satisfaction and awareness and attitudes of community groups toward the center are presented.

A third resource for citizens is *Citizen Evaluation of Mental Health Services: An Action Approach to Accountability* (MacMurray et al. 1976). Like the materials described above, this publication focuses on accountability and describes this process in four steps: (1) organizing the citizen accountability team; (2) assessing mental health problems and resources; (3) evaluating specific programs and services; and (4) using the results of those evaluations. The authors describe various approaches to community needs assessment and provide additional advice to citizens on what to evaluate and how to collect data. Finally, another useful resource for citizens is the Mental Health Association's *Community Mental Health Center Site Visitation Handbook* (1976). This handbook includes a site visitation form and the types of information that are necessary in reviewing center services.

In addition to the publications that deal directly with the issue of citizen involvement in mental health evaluation, a number of recent publications address mental health evaluation in general.

Though directed toward administrators and professional evaluators, *Resource Materials for Community Mental Health Program Evaluation* (Hargreaves et al. 1979) is a useful resource for citizens since it presents both background information on evaluation and case examples in clear and relatively nontechnical terms. Also of use to lay citizens are those articles in the document that address evaluation of service effectiveness. This particular section contains a review of measurement instruments and references for further information.

Another useful resource is *Evaluation in Practice: A Sourcebook of Program Evaluation Studies for Mental Health Care Systems in the United States* (Landsberg et al. 1979). The editors of this monograph have compiled a series of cases that illustrate program evaluation as it is actually conducted in mental health facilities. Again, the intended audience is program administrators and evaluators; however, the cases are understandable and highly instructive for laymen as well as for professionals. Topics such as program acceptability, availability, accessibility, and awareness are illustrated in the cases and should be particularly useful for citizens who are interested in examining these issues in their communities.

More technical information on methods and research designs is presented in a monograph entitled *A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers* (Hagedorn et al. 1976). Although this manual presents more sophisticated methodological information than the other publications cited here, it might be helpful for those citizens who are undertaking more ambitious projects. Methods for needs assessment, analysis of patterns of service use, cost analysis, and studies of client outcome are described in the manual.

The remaining chapters of the *Casebook* describe the 51 cases selected. Each chapter begins with a boxed hypothetical case that illustrates some of the major issues discussed in the chapter. This is followed by a chapter introduction that summarizes the actual cases. Finally, each chapter includes a number of cases that have been selected because of their relevance to the chapter's concerns.

Where Are You in the System?

Doug Brown is an active member of the Greene County Mental Health Association (GCMHA). The association, composed of interested lay persons, consumers, and mental health professionals from the community, has recently become concerned about the need for short- and long-range planning in the county's mental health system. The need for planning has been underscored by recent funding cutbacks and pressure to reexamine the county's service priorities. In order to prepare a plan, however, there is a need for an evaluation of the county's mental health needs and service availability. In response to this concern, the board of directors of the GCMHA set up a planning and evaluation committee and appointed Doug Brown as chairman.

Doug and his committee have a number of key decisions to make before actually collecting information and developing planning and policy recommendations. The first consideration that Doug must put before the committee is a discussion of the inherent strengths and limitations of any GCMHA-sponsored evaluation based on the organization's position in the system and its reputation in the county. One of the strengths that Doug can count on is the association's independence and freedom from any potential conflict of interest. Further, the association has worked hard to reflect the interests of all elements of the community in its advocacy for improved services and has therefore won the respect of the major constituencies in the county. Finally, GCMHA has been very active in the State capital and has successfully lobbied for increased funding for the Greene County Mental Health Department. As a result, GCMHA has a cooperative and reasonably productive relationship with the county mental health agency.

Unlike the county's mental health advisory board, however, Doug and his committee do not have automatic access to county-supported services or to their records. Further, many of Doug's committee members are not familiar with the range of services offered in the county since GCMHA's focus for the last several years has been on children's programs. Finally, the evaluation is only one of GCMHA's activities, and therefore Doug and his committee will have to compete with other association committees for resources and attention.

All of these considerations are crucial because of their influence upon the level of participation that Doug and his committee commit to the evaluation, the scope of their exploration, the issue or issues they take on, the means they choose to get answers, and the steps they take to ensure that their recommendations are integrated into county mental health policies and plans.

The cases that follow show citizens and consumers functioning in a variety of contexts from State advisory councils and agency boards to client groups. Each organizational location brings with it a different perspective and orientation which in turn shapes the evaluation or monitoring activity conducted.

State Council

The first case in the chapter, written by Dennis Geersten and Jean Okawa, describes the activities of a State planning and advisory council that launched a statewide assessment of mental health problems and the needs of special populations

(e.g., chronically mentally ill persons). The broad mandate of the council coupled with its access to State-level planning processes means that it is capable of taking on more general and all-encompassing tasks and that its requests for information are likely to receive swift and serious responses. Further, given its position in the system, the council's recommendations--as shown in the case summary--stand a good chance of being integrated into the State's mental health plan.

Regional or County Board

The next two cases involve sub-State citizens' groups, one on a regional level and the other on a county level. The regional advisory board, described by Jessica Wolf in case #3, has very specific State-mandated responsibilities, and the format for agency review and evaluation is equally specific. This particular regional citizens' group functions in tandem with local catchment area councils and works in partnership with the regional mental health commissioner. Because the regional body is responsible for funding recommendations, its reviews carry a great deal of weight. The formal power of the group also tends to facilitate the implementaton of recommendations. In this case, however, the formal position of the group may also have engendered a certain amount of defensiveness in the agency being evaluated given the fear of cutbacks in funding. The county advisory board, described by Dan Hustedt in case #2, also has the advantage of working under a very specific State mandate that spells out the board's responsibilities for program review. The specificity and formality of its functions ease the board's access to county-funded agencies and guarantee at least an audience for its recommendations. The role and functions of both of these boards, however, dictate that the majority of their activities are carried out in partnership with mental health agency staff.

Agency Board

The fourth case, written by Jarrett Richardson, involves the activities of an agency board of directors. The assessment described was motivated by the board's desire to assess agency performance after 2 years of operation. The board, which is broadly representative of the community, has responsibilities in a variety of areas including personnel, admissions, finances, administration, and evaluation. The case illustrates that boards of directors don't have to confine their efforts to internal agency reviews, but can also use knowledgeable persons in the community and agency consumers as sources of information. The case also raises the question of how much time should be devoted to evaluation tasks by board volunteers with multiple and competing agency responsibilities.

External Group

Citizens' groups that function independently of a service system can also play a significant role in program monitoring and evaluation. Darlene Humphrey describes the experience of one such group whose mission is to monitor services for frail and vulnerable persons in nursing homes. The experience of Ms. Humphrey's group, like that of other monitors, reinforces the fact that the routine presence of an outside observer can reduce abuse and neglect in residential facilities. The case also points out the profound influence that an external public interest group can have on a program--in this instance, the agency was successful in eventually pressuring the State to close a substandard nursing home. A disadvantage of being an external group is also pointed out by this case--the difficulty in securing access to facilities in order to carry out adequate monitoring.

Consumer Group

Case #6 reflects the types of evaluation activities that can be undertaken by consumer organizations--in this instance, a local mental health association. The case, written by Nancy Sohlberg, shows how a local consumer group can both evaluate a major service provider and maintain a mutually respectful and increasingly cooperative relationship. The case further illustrates how a consumer group like a mental health association can sharpen its mission by including consumers of services as sources of information. In contrast to county and regional advisory boards, this case shows a possible strength associated with independent consumer evaluators--the absence of defensiveness on the part of the subject of evaluation.

Community Mental Health Center Board

In addition to the earlier case example of an agency board evaluation, the next case exemplifies the sort of monitoring and planning activities that can be undertaken by a board of a community mental health center. The case, described by Roger Strauss, traces the evolution of a CMHC board's involvement from a somewhat passive role as recipient of information to one of active particiption in the assessment of needs and the development of rational funding strategies. The discussion also points out that the level of satisfaction of CMHC board members increases substantially as they increase their involvement. Finally, the case shows how CMHC boards can create new roles and responsibilities in program evaluation now that the Federal guidelines and site visits have been eliminated.

Board of Visitors/Quality Monitors

Case #8 revolves around the activities of a

board of visitors at a State hospital. It is reflective of the activities carried out by such bodies and the types of problems they are likely to encounter. This case, written by Marilyn Seide, indicates that boards of visitors should sharpen their client-centered missions in order to avoid being drawn into staff-related concerns. It also points out the delicate balance that such groups of monitors must maintain between cooptation on the one hand and unproductive confrontation on the other.

Advocacy Group

The use of consumers of services as quality assurance monitors is the focus of case #9, related by David Schott. The organization sponsoring the monitoring activity is an advocacy group that represents the rights and interests of mentally disabled persons. The case shows how an advocacy organization can mobilize its clients to work for the improvement of services on their own behalf. It also suggests that advocacy groups, in particular, can be influential in advancing the consumer's view of service quality and contrasts this view with that of case managers and others vested with quality-assurance responsibilities.

Client Group

The final case in this series focuses on a patient group within an inpatient facility and discusses how such groups can influence facility policy and assist in the resolution of client grievances. The case, written by Gabriel Manasse in consultation with Charles Gold, describes the evolution of the patient group and its increasing influence and range of activities. It also points out the difficulties of maintaining continuity within such groups and the problems some clients may have in sitting in judgment on clinicians from whom they may also be receiving treatment.

1. State Council Assesses Utah's Mental Health Needs

Dennis C. Geertsen

Utah State Division of Mental Health

Jean Okawa

Utah State Planning and Advisory Council

SUMMARY

The Utah State Planning and Advisory Council, in collaboration with the Division of Mental Health, conducted a needs survey of key informants throughout the State of Utah. Respondents indicated their priority selections of target populations whose mental health needs were not being met, and the major mental health problems and service needs associated with each target population. The evaluation results were initially shared with selected staff and advisory council members by means of an oral report and slide presentation. A written report is scheduled for completion.

TYPE OF ORGANIZATION

The advisory council is composed of 20 residents from nine community mental health catchment areas throughout the State. Council members include housewives and working women (35 percent), educators (10 percent), lawyers (5 percent), paraprofessionals working within the State mental health system (10 percent), and mental health professionals within (25 percent) and outside (15 percent) the system. These people are appointed to the council by the State board of mental health. The role of the advisory council is to advise the Division of Mental Health in the development, coordination, and evaluation of comprehensive mental health plans for the state.

EVALUATORS OR MONITORS

This study was carried out by the Advisory Council and the Division of Mental Health evaluator who acted as project coordinator.

REASONS FOR EVALUATION OR MONITORING

The combined views of key informants (knowledgeable persons) who are and who are not part of the mental health delivery system is an important component in assessing the mental health needs of the state. This study was intended to assess the perspectives of key leaders and non-mental health providers regarding priority target populations, problems, and service needs. The study was undertaken to gather relevant data for mental health planning in Utah.

For further information write Dennis C. Geertsen, Ph.D., Chief, Program Evaluation and Research, Division of Mental Health, 150 West North Temple, Room 336, Salt Lake City, UT 84110, (801) 533-5783.

LEVEL OF PARTICIPATION

Citizens were involved as both research assistants and key informants. As researchers, members of the advisory council assisted in planning the study, formulating questions, developing and pilot testing the questionnaire, developing the method for sampling potential study participants, and coordinating and encouraging respondents within their district to participate. Technical aspects of these tasks were carried out by, or under the supervision of, the authors. In addition to being involved as researchers, council members at State and local levels were designated as part of the sample to receive mail questionnaires.

TARGET OF EVALUATION OR MONITORING

This study focused on the multiple needs of persons residing in all service areas in the State of Utah. Four of the nine service areas lie exclusively in rural areas of the State, while most of the others have at least one county which is rural. Seven of the areas are served by comprehensive mental health centers. There is only one State hospital, which underscores the strong emphasis in Utah on community-based care. Utah is predominantly white (92 percent) and has a relatively large household size, averaging 3.2.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Issues evaluated in the needs assessment included target populations and problem areas felt to be of interest to public mental health programs in Utah. The target populations were: (1) ethnic-racial minorities, (2) chronically mentally ill, (3) elderly, (4) adolescents, (5) children, and (6) the general population. Rather than evaluating service programs, this study focused on specific problems related to mental dysfunction.

TECHNIQUES USED

The project coordinator and the chairperson of the advisory council designed the key informant survey, drafted the questionnaire, selected the random sample, mailed out questionnaires, and analyzed and reported the results. The group of respondents included all local advisory members and a randomly selected sample of other names (up to 50 persons) from lists that were identified as key referral sources. The total sample was 185 persons, of whom 45 percent sent back questionnaires.

FINDINGS OF EVALUATION OR MONITORING

Preliminary results for the State as a whole include the ranking of mental health problems for six target populations. The ranking of target populations whose needs are perceived as not being met were also examined. The three highest ranking problems were "disturbed family relations," "alcohol abuse," and "social isolation." However, these and other problems varied somewhat by target population. Target populations not being adequately served were ranked in this order: children, adolescents, and elderly (tied for first); ethnic/racial minorities (second); the chronically mentally ill (third); and the general population (last). Former Federal mandates and current State mandates specify the chronically mentally ill as a high priority. Respondents to this study apparently felt that the needs of this population were being met, at least in relation to other target populations.

RECOMMENDATIONS

Detailed recommendations will be developed upon completion of the analysis and report. Two general recommendations are as follows: (1) State and Federal mental health agencies should reconcile differences between need priorities of target populations with those priorities identified by other local referring agencies, and (2) citizen participation should more often be included in future evaluations, recognizing that this involvement can be cost effective and contribute to study quality.

STEPS TO ENSURE IMPLEMENTATION

The following implementation steps were projected: (1) present preliminary results to the advisory council, the division of mental health, local and State boards, and program directors; (2) include results in early drafts of the mental health plan; (3) develop detailed recommendations and a final report; (4) disseminate the final report to the above groups and other interested agencies; and (5) assess utilization of study results through followup contacts with the responsible agencies.

EXTENT OF IMPLEMENTATION

Preliminary reports have been presented to the advisory council, the division of mental health, and the mental health plan steering committee. A written summary has been included in a draft of the State mental health plan. Other steps are now in the process of implementation.

SPECIAL BARRIERS OR SUPPORTS

Because of limited resources and small staff (one evaluator), the study could not have been undertaken without citizen involvement. The advisory council members were viewed by the State Division of Mental Health as being experts in their local geographic areas pertaining to sample selection, coordination, and identification of problems that subsequently became content for

the questionnaire. Council members helped to legitimize the study by making contact with other key informants in their own local communities.

Some council members felt that the project moved too slowly in the early phase. This situation was due to the limited research experience of council members and unavailability of technical assistance to the council. The lack of concentrated time and effort by advisory council members (i.e., infrequent monthly meetings) was an additional barrier. However, the above problems were resolved and the project proceeded once the technical research consultation was made available by the State Division of Mental Health. Research and financial aid from the division were essential resources in planning, implementing, and completing the study.

RESOURCES AND COSTS

The total cost for the study was $8,368. Approximately 68 workdays were used to carry out the project, including 40 days by council members (cost: $2,268) and 27 days by State staff (cost: $3,350). These personnel costs were donated to the project by the State agency and individual council members. Additional expenditures for travel ($2,500) and printing ($250) resulted in total out-of-pocket expenses of $2,750. Almost three-fourths of the total cost of the study was donated by agency and council volunteers, who proved to be important resources.

ADDITIONAL COMMENTS

Study participants felt that this project was a very successful example of a collaborative research endeavor between State and local agencies and citizens. A major benefit of the project was the inclusion of a broad-based perspective of mental health needs for State planning. Another benefit is the research resource provided by active volunteer community participants, which is especially an asset during times of tight agency budgets.

2. Site Visit Reviews in Monterey County

Dan Hustedt

Monterey County Mental Health Advisory Board

SUMMARY

The Monterey County Mental Health Advisory Board (MHAB) conducts an annual site review of each program receiving funding under California's mental health statute--the Short-Doyle Act. Board members examine service goals and objectives, types of services provided, primary problems dealt with, existing alternatives for service, facility operations, location, service capacity, utilization, staffing, program organization, and administration, unmet needs for service, and referral patterns. Site review reports which include MHAB conclusions and recommendations are written and distributed to board members and service providers. Service providers are asked to respond in writing to conclusions and recommendations of the site review team.

TYPE OF ORGANIZATION

The membership of the Monterey County MHAB and county boards throughout California is mandated by legislation that also governs community mental health programs. The board must include 17 members--5 must be representative of selected disciplines, 2 must be physicians, 5 must either be consumers or have immediate family members who have been consumers of mental health services, and 4 members must be representatives of the public health interest in mental health. In addition, by law the board must be representative of the county population in terms of age, sex, and race or ethnic group. The duties and functions of the MHAB are as follows:

- Review and evaluate the community's mental health needs, services, facilities, and special problems
- Review the county mental health plan
- Approve the mental health planning process
- Act in an advisory capacity to the local mental health director and the board of supervisors

EVALUATORS OR MONITORS

Each site review team included the local mental health director, the program evaluator, clinical personnel with some day-to-day dealings with the program being reviewed, and at least two representatives of the MHAB.

For further information write Dan Hustedt, Staff, Monterey County Mental Health Advisory Board, 1270 Natividad Road, Salinas, CA 93906, (408) 424-0946.

REASONS FOR EVALUATION OR MONITORING

The annual site reviews are an integral part of the Short-Doyle planning process. The information from the reviews provides board members with some of the knowledge they need to make decisions concerning planning for program increases or reductions. It also provides an opportunity for clinicians in the system to become more knowledgeable about other programs and to supply constructive criticism as needed.

LEVEL OF PARTICIPATION

MHAB members participate in the following ways:

- Review and approve the site review protocol
- Attend the site reviews
- Provide ideas for the conclusions and recommendation section
- Review and approve both the consensus site review writeups and the service provider feedback reports

TARGET OF EVALUATION OR MONITORING

The site review process was repeated at each of the 20 mental health programs funded by Monterey County. Operating under State legislation mandating community mental health programs for counties with populations over 100,000, the Monterey County mental health budget for 1982 is slightly less than $7 million. The services are designed to serve a population of 292,000. The full range of mental health services is available in both of the county's two catchment areas. In keeping with State priorities, over half of the services are operated through contracts with private agencies.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Board members examine service goals and objectives, types of services provided, primary problems dealt with, existing alternatives for service, facility operations, location, service, capacity, utilization, staffing, program organization and administration, unmet needs for service and referral patterns. All services are rated in terms of the importance of their goals and the program's efficiency in meeting these goals.

TECHNIQUES USED

For each service, an agreed upon set of statistics depicting both the program activities for the previous year and relevant cost data is supplied to all reviewers. The site review protocol is then administered and site review conclusions are recorded.

FINDINGS OF EVALUATION OR MONITORING

A site review report for each program was distributed to all board members and to each service provider. Each service provider was asked to respond in writing to any questions, comments, or suggestions and criticisms recorded in the site review conclusion section. A document titled *Provider Feedback to MHAB Site Review Conclusions* was then prepared.

In addition to the findings described in the site visit report, reviewers are also required to rank the goals and objectives of each program according to priority and to assess the program's efficiency. This information is later used as input to MHAB's consensus ratings of all mental health services offered in the county and the consensus ranking of all needed services.

RECOMMENDATIONS

Recommendations were included in the consensus writeups and responded to in the *Provider Feedback* document. In addition, the advisory board's priorities were used to assist in determining necessary program reductions for the following fiscal year.

STEPS TO ENSURE IMPLEMENTATION

The board asked that providers respond to their recommendations. The recommendations, however, are not binding, and service providers are ultimately responsible to the county program direction in regard to operations. Since the reviews are made on an annual basis, service providers are called upon to address problems they had agreed to remedy from the previous year's review. In practice, many of the MHAB recommendations have been implemented by the providers.

EXTENT OF IMPLEMENTATION

With major funding reductions in the mental health program in the past year, the county mental health program eliminated the lowest priority services as rated by the MHAB.

SPECIAL BARRIERS OR SUPPORTS

The program chief and the MHAB staff member arranged for the reviews and coordinated all the scheduling of clinical time for the review effort. All of the programs cooperated in providing the necessary information to make the review process effective.

RESOURCES AND COSTS

The costs for mailing, typing, and xeroxing were absorbed by program administration. The other costs were the approximately 70 hours of the program chief's and evaluator's time in attending the reviews. Also, the time of various clinical review team members and service providers was an additional cost to the system.

ADDITIONAL COMMENTS

The findings of the review teams are not always the most important element of the process. The concept behind the reviews is that they allow the MHAB members a means of regularly studying mental health system operations so that they can intelligently communicate the community's perspectives to the policymaking process. Without the annual reviews, board members do not feel adequately informed to evaluate the community's mental health needs, services, facilities, and special problems as they are mandated by law to do.

3. Collaborative Regional Review of Keystone House

Jessica Wolf

Southwest Regional Office
Connecticut State Department of Mental Health

SUMMARY

Connecticut law mandates that regional mental health boards (RMHBs), subarea catchment area councils (CACs), and the State-employed regional mental health director regularly review programs funded with State department of Mental Health community grants-in-aid. According to the law, the regional mental health boards, together with the regional mental health director, must make recommendations to the commissioner of the department of mental health concerning the funding of community mental health programs.

The subject of this review is Keystone House--an agency that operates a halfway house and an independent living apartment program. Findings of the review included the need to increase occupancy rates, change admission requirements, and develop measurable goals. Though there was some conflict between reviewers and the agency, the spirit of compromise prevailed and the recommendations were implemented.

TYPE OF ORGANIZATION

The regional mental health board (RMHB) consists of 16 members of whom four are appointed from each of the four CACs. A majority of the members of the RMHB must be consumers (i.e., nonproviders of mental health care). RMHBs are funded through State department of mental health grant-in-aid funds as well as through local funds. The regional boards employ their own staff.

RMHB procedures place the initial responsibility for program review at the CAC level. A panel, generally composed of three CAC members, RMHB staff, regional director, and assistant regional director, meets after the staff has developed preliminary information concerning the agency, program, and financing. The panel members determine the questions they wish to ask during the site visit. The site visit is held at the agency and includes representatives of staff and the agency board. Following the site visit, the panel reconvenes to discuss the visit and issues raised there. An RMHB staff person then develops a preliminary review report, which is circulated to the panel members, the remaining members of the CAC, and the agency.

The next step is consideration by the CAC at a regular monthly meeting. Agency staff and board members are invited to answer questions. After CAC members vote, the review report is circulated to the members of the RMHB, who discuss the report with agency representatives. The regional mental health director is present throughout all these meetings. After the final action is taken, the regional mental health director forwards the review report to the commissioner of mental health and agency representatives.

EVALUATORS OR MONITORS

In general, efforts are made to include both consumers and service providers on review panels. In the Keystone House review, there were two providers and one consumer. One provider was the administrator of a nearby drug abuse treatment program, and the second was the administrator of a private psychiatric hospital. The consumer was the administrator of a local transportation agency who had been active in mental health affairs and had at one time been a board member of Keystone House. The executive director of the regional mental health board, the regional mental health

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the importance of program evaluation and made efforts to change their own programs when it was time for them to be monitored. The board enjoyed working with the staff. Board members also got to see programs from a different perspective and to view themselves as agents of change in the agency, not just passive recipients of information.

The monitoring process has a definite flaw. The standards and evaluation committee was only activated after site reviews. With the loss of all Federal funding there have been no site reviews for the past 18 months. Further, the State has not conducted a comprehensive evaluation of any center for 2 years. Therefore, the standards and evaluation committee has not met for nearly a year.

8. Board of Visitors Monitors Service Quality

Marilyn Seide

Board of Visitors, Manhattan Children's Psychiatric Center

SUMMARY

The board of visitors of the Manhattan Children's Psychiatric Center was formed in 1978--6 years after the facility opened its doors. The board is part of a larger network of citizen overseers mandated by State law and attached to all State mental health facilities in New York. The board consists of family members, interested lay persons, and mental health professionals. It meets monthly, conducts investigations of client abuse, reviews incident reports, and makes numerous site visits. The major challenge to the board is to maintain independence while preserving the trust and cooperation of the management of the center.

TYPE OF ORGANIZATION

The New York State Legislature established boards of visitors for mental hygiene facilities over 50 years ago. These lay boards are usually composed of seven people from the community (three of whom are parents or relatives of patients or former patients) who are knowledgeable about, and interested in, the welfare of the patients in the facility they represent. Members are responsible for oversight and monitoring of the quality of care and treatment in each of the 56 mental health and mental retardation facilities in New York State. They are appointed by the Governor to serve 4-year terms, and may be reappointed. Members are not paid, but may be reimbursed for expenses incurred in carrying out their responsibilities. Though boards may function differently from each other, there are certain specific tasks that they are uniformly expected to carry out. The board that plays the central role in this case description is responsible for monitoring service quality at the Manhattan Children's Psychiatric Center (MCPC).

EVALUATORS OR MONITORS

Though the Manhattan Children's Psychiatric Center was officially opened in June 1972, the first members of a board of visitors for the facility were not appointed until the spring of 1978, when the first meeting was called by the director of the MCPC. Among the original members of the board were a prominent mental health advocate who was the executive director of a mental health association, a chairman of a committee on the handicapped who was the parent of a child who had been an inpatient at the facility, two social workers with extensive experience in the field of children's mental health, a lawyer from the juvenile rights division of the Legal Aid Society, another parent of a child formerly at the center who worked part-time as an aide in a public school, and a mental health hospital administrator. Thus, through training, interest, experience and/or expertise, this board was well equipped to carry out its responsibilities as advocates for the children who were clients of the center.

REASONS FOR EVALUATION OR MONITORING

The functions of the boards of visitors are spelled out in State law and are generally directed toward assuring of the well-being of residents of State facilities.

LEVEL OF PARTICIPATION

Boards of visitors are both advocates and independent watchdogs. Though they share a commitment to the provision of optimal patient care with those who are vested with the responsibility for delivering care and treatment (the State Offices of Mental Health, and Mental Retardation and Developmental Disabilities), board members do not always agree with those in the system about how care and treatment are being provided. This explains why the board is occasionally perceived by State officials as an

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director, and the assistant regional mental health director completed the team.

REASONS FOR EVALUATION OR MONITORING

As indicated above, State law requires review by the RMHB and regional director. In Region I of Connecticut, full reviews of the 20 community grantee agencies are undertaken at least once every 3 years. Partial reviews may be undertaken when indicated.

LEVEL OF PARTICIPATION

Citizens serving on the review panel, CACs, and RMHB participated as partners or colleagues with RMHB and State staff in the assessment of Keystone. They were joint participants in the collection and assessment of information and the formulation of recommendations.

TARGET OF EVALUATION OR MONITORING

The Keystone agency includes a halfway house and a supervised apartment program for persons discharged from psychiatric hospitals. The service area consists of four towns, although Keystone also takes referrals from other parts of the region if beds are available. Clients are referred primarily from a general hospital, the State hospital serving the region, and a private psychiatric hospital. The halfway house presently has ten beds; however Keystone has received an award from the Department of House and Urban Development (HUD) to renovate the house and to add two beds. The apartment program consisted of two rented apartments with a total of five beds, although it was realistically possible to use only four. The program is staffed by an executive director and the equivalent to 4 ½ additional staff, primarily counselors.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The review focused on programmatic and fiscal issues including the role of the board of directors, staff assignments, the status of the HUD grant, interagency relationships, ease of referrals, and followup of former residents. Specific issues of concern to the panel included the costs of the apartment program, its apparently low occupancy in the previous year, and the agency's policy that only graduates of the halfway house could be admitted to the apartment program. In addition, there was concern that the agency was receiving funding for five beds when in fact only four could be used.

TECHNIQUES USED

A document titled *Standards for Funding* was mailed in the fall of 1981 to the executive director of the agency with a request for response. In addition, service utilization information was gathered by the RMHB and the regional director was responsible for collecting cost data. Panel meetings, a site visit, a meeting with board members and staff, and CAC and RMHB meetings, also occurred. Additional data were requested from the agency, including more up-to-date information on costs and plans for interrelating the HUD grant with ongoing agency operations. Dissatisfaction was expressed by the review panel because, according to panel members, they had difficulty in obtaining complete information. Agency representatives complained that the information requested, once provided, was not considered carefully enough.

FINDINGS OF EVALUATION OR MONITORING

In the first draft of the review, the panel recommended defunding the apartment portion of the Keystone program because the occupancy was low (54 percent) for the previous year (1980); the State grant stipulated at least 80-percent occupancy; and the low occupancy rate resulted in higher unit costs. The draft report also noted the agency's inability to accept outside clients to the apartment program. At this stage, there was a climate of distrust and even hostility between members of the review panel and some agency representatives. Agency representatives complained that they were attempting to respond to the review while also developing voluminous materials related to the HUD grant. Further, they felt that the review panel and CAC were "out to get them."

The catchment area council accepted the report of the review panel and forwarded it to the regional mental health board. On the day of the RMHB meeting, the Keystone House staff made available more recent information (for 1981) on utilization and cost which showed that occupancy in the apartment program had increased, while it had declined in the halfway house.

RECOMMENDATIONS

Based on the new information, the review panel met again and reaffirmed its recommendation. The CAC, however, recommended funding of the apartment program on the following conditions: (1) that an agency policy statement be developed (and approved by the CACs by September 30, 1982) that provided for admission of clients directly to the apartment program; (2) that utilization and occupancy rates be based on four beds; (3) that occupancy should be 95 percent; (4) that efforts be made to secure space for five beds when leases were renegotiated; (5) and that measurable program goals and objectives be developed and submitted to the CACs. The terms

were met by the agency by the end of September 1982.

Specific recommendations included: that a log of telephone calls be kept by the agency in order to ensure that vacancies were promptly filled, and that Keystone clients increase their utilization of other local mental health resources.

STEPS TO ENSURE IMPLEMENTATION

Keystone was required to submit a report to the CACs on its policies concerning direct admission to the halfway house, specific measurable goals and objectives, and documentation of the 95-percent occupancy rate. These conditions are also incorporated into the letter of award from the department of mental health. Information about the review was published periodically in the local press, and meetings at which the review was discussed were public.

EXTENT OF IMPLEMENTATION

Most of the conditions have been met. The agency will be expected to report periodically to the CACs and RMHB regarding the occupancy rate in the apartment program and efforts to find new apartments. Quarterly utilization reports are also submitted by all grantees to the RMHB and regional director which show sources of referral and number of clients in residence.

SPECIAL BARRIERS OR SUPPORTS

There was very active involvement from all who participated in the review. However, there were personality and conceptual clashes between the members of the review panel and the CACs on the one hand, and the agency board and staff on the other. In part this may have resulted from the extensive amount of time that implementation of the HUD grant required and the perception by agency representatives that the reviewers were operating unconstructively. The review panel had difficulty obtaining materials in a timely fashion and were concerned that the apartment program was not a cost-effective expenditure of scarce grant funds. In addition, there was a major change in the agency's board membership in the course of the review, which temporarily hampered the ability of these new, somewhat inexperienced members, to participate fully and clearly in the review process. The lack of available information on the most recent year's costs was problematic for the review committee, and its submission on the day of the RMHB meeting left little alternative but to refer the report back to the CACs.

The lack of reliable comparable data on staffing, costs, grants, and utilization of other halfway houses throughout the State and the lack of a policy within the department of mental health regarding funding of halfway houses and apartment programs were also constraints.

The existence of a defined agency review procedure and a format for review reports was helpful in structuring the review process. Other facilitating factors included the recognition among volunteers on the catchment area councils and regional mental health board of the critical need for housing programs for discharged psychiatric patients, the desire of the volunteers to avoid defunding an existing program, their commitment to doing the right thing, and their acceptance of the final decision of the regional board.

RESOURCES AND COSTS

It is difficult to estimate exactly the amount of volunteer and staff time involved. There were four meetings of the panel, two CAC meetings involving 16 people, two RMHB meetings involving up to 16 people, and innumerable hours of staff time in developing the information, drafting reports, responding to agency requests, evaluating information, etc. This review took about a year from start to finish, which is almost double the time a review ordinarily takes. In terms of RMHB staff time, a cost of about $3,000 is an approximate figure. If the value of time offered on a volunteer basis is estimated, and $30 per hour is considered the average value of time offered, then a minimum of $3,000 of time was used. This does not include the costs of reproducing reports, or the time used by agency staff and board, or the regional director's office.

ADDITIONAL COMMENTS

It probably would make sense to conduct an orientation with grantee agencies on some regular basis, perhaps annually, on the goals and methods of the review process. Agencies may respond defensively because they are frightened of losing funding. Reviewers are caught between their dual role of advocating and sustaining services for the mentally ill, and fulfilling their review mandate by undertaking substantial and thorough evaluations. There are bound to be some occasions when these conflicting requirements pit agencies and reviewers against one another. The emotional reactions which can result may cloud the fundamental issues of provision of service and constructive criticism.

The Keystone board of directors felt constrained by their legal advice concerning the acceptance of outside clients into the apartment program. The CACs and regional board felt that they were paying for five beds when only four were being used. Ultimately, both sides compromised; the RMHB agreed to fund four beds at least for the immediate future, and Keystone agreed to accept outside clients into the apartment program. Though there was discomfort on all sides, an acceptable accommodation was negotiated among all parties.

Finally, it is important that volunteers also be oriented and trained concerning what is expected of them during the review process. Review and evaluation require knowledge of program content and cost, as well as an understanding of the politics of interagency relations. Finally, these tasks require courage to raise and deal with thorny issues.

4. Volunteers Assess the Operations of a Halfway House Program Serving the Chronically Mentally Ill

Jarrett W. Richardson

Thomas Group, Inc., Minneapolis

SUMMARY

The Thomas Group board of directors charged a subcommittee with the task of evaluating the degree to which the Thomas House Halfway House program was meeting its stated goals. The implicit task of the committee was to identify areas of strength and weakness and bring to the board's attention recommendations for further program development.

TYPE OF ORGANIZATION

Thomas Group, Inc. is a private, nonprofit organization governed by a volunteer board of directors made up of consumers and relatives of consumers, professionals working in the mental health field, and civic leaders with an interest in mental health. The primary purpose of the board is to create and operate adequate transitional living services for the area's recovering mentally ill. There are 21 board members nominated from the community and elected to membership by the board of directors. Normal responsibilities for the board of directors include participation in monthly board meetings as well as participation in a variety of subcommittees such as personnel, admissions, finances, executive, and evaluation committees.

EVALUATORS OR MONITORS

Three members of the Thomas Group board of directors--a housewife, a minister, and a psychiatrist--were appointed to the program evaluation committee.

REASONS FOR EVALUATION OR MONITORING

This effort was prompted by the desire of the board of directors to evaluate the degree to which Thomas House was meeting its stated goals after more than 2 full years of operation. This was to be an in-house evaluation for the purpose of assessing and improving the Thomas House program. This is in addition to an ongoing evaluation for each individual resident that was instituted at the beginning of Thomas House operation by the board of directors and carried out by the Thomas House staff.

LEVEL OF PARTICIPATION

This entire evaluation was carried out by the three members of the program evaluation committee with the assistance of the director of Thomas House Halfway House, who has some expertise in conducting evaluations. The evaluation also benefitted from a single consultation session volunteered by an independent professional planning consultant. The committee conceived, designed, and organized an evaluation instrument. They also tabulated and interpreted the data and prepared a comprehensive report for the board of directors. Clerical assistance was provided by the staff of Thomas House but tabulation, interpretation and report writing were done entirely by the committee.

TARGET OF EVALUATION OR MONITORING

This evaluation focused on Thomas House, a 3-year-old, 16-bed transitional living house that serves individuals who spend approximately 6 months to 1 year learning or relearning independent living, socialization, leisure, and community survival skills. The survey included all names submitted by members of the Thomas House board, all present and past Thomas House residents, all Thomas House board members, all present and past Thomas House staff, and families, and personnel from community mental health, social welfare, employment and educational organizations who had significant contact with Thomas House and its residents. Thomas House Halfway House serves Olmstead County, which has a population of approximately 80,000.

The survey was conducted during that period of time when Rochester State Hospital, which was

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the referral hospital for the State hospital system, was being closed as a result of State budget action. The presence of the Rochester State Hospital had led to a very stable and progressive public sector within the mental health community, and that hospital had been the primary source of referrals for Thomas House. In spite of the fact that the mental health community was in a significant state of flux during the time of this evaluation, the extensive community support for Thomas House and high level of interest in the activities of Thomas House among health care professionals resulted in a good response to the evaluation effort.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

This evaluation focused on the stated program purposes of Thomas House Halfway House. More specifically, the programing needs addressed were focused on attitudes, knowledge, and skills of present and former residents with respect to financial, leisure, social, homemaking, personal hygiene, illness management, and educational or employment activities. The evaluation was an effort to assess the effectiveness of the program in achieving its stated goals as reflected in knowledge, attitude, skills, and experience of the present and former residents.

TECHNIQUES USED

The committee reviewed all available public documents that contained statements concerning the Thomas House program. This included the articles of incorporation, the bylaws, requests for funding and program description under Minnesota Rule 22, brochures, and public documents such as newspaper articles. There were more than 65 different documents reviewed for mention of the Thomas House program. A list of approximately 75 assertions were obtained and classified into major areas of program focus. These statements were condensed into 25 client-centered goals and a survey format was designed. This survey was designed as a general document, applicable to a broad range of people with a great deal of variation in their level of involvement in the Thomas House program. The survey requested that the various respondents assess the agency's effectiveness in meeting its avowed goals of improving clients' performance in 25 different aspects of community living.

A single mailing of the Thomas House survey with an attached cover letter and self-addressed stamped envelope was done in the summer of 1981. The program evaluation committee subsequently divided respondents into groups with common characteristics and analyzed the responses of each group. Respondent groups were: current residents, former residents, parents of residents, social workers, Rochester State Hospital employees, psychiatrists, psychologists, educational instructors, Thomas House employees, and board members.

FINDINGS OF EVALUATION OR MONITORING

Forty-eight percent of the sample responded to the questionnaire. The committee interpreted the overall results of the survey as demonstrating Thomas House's effectiveness in improving client performance. However, present and former residents perceived the fulfillment of almost all program goals in a slightly less favorable light than did all other groups of survey respondents. Specific areas of greatest weakness as perceived by present and former residents were: (1) buying and taking care of clothes; (2) managing personal finances and using community financial resources; and, (3) using community spiritual resources. The committee noted the difficulty of understanding what the term "community spiritual resources" meant to present and former residents (there is no statement in the Thomas House program documents concerning spiritual aspects of the program). However, since concern was expressed, this area was thought to deserve further clarification in the future.

RECOMMENDATIONS

The program evaluation committee of the Thomas House Board commended the board of directors of Thomas House for achieving the vast majority of its stated program goals and asked that this be communicated to the staff. The committee recommended that specific attention be given to the areas of clothing and financial management in future program planning and also recommended that further clarification be given to ways in which spiritual/religious needs of residents are met within the program or to what degree the program staff could appropriately address those needs. The committee recommended that at some time in the future a more specific program evaluation directed primarily at former residents and their families should be conducted.

STEPS TO ENSURE IMPLEMENTATION

Since this was an in-house evaluation made to the board of directors and the staff of Thomas House Halfway House, implementation measures were the direct responsibility of the board.

EXTENT OF IMPLEMENTATION

Immediate changes were forthcoming in the Thomas House program as recommended by the evaluation committee.

SPECIAL BARRIERS OR SUPPORTS

The primary difficulty with this evaluation was designing an instrument that could be used by a wide variety of residents and other people associated with Thomas House. An additional problem was that of assuring an adequately high response rate for the survey. Because of the broad spectrum of activities involved in the Thomas House program, detailed assessment of every aspect of the program would have necessitated too cumbersome a document for careful response from a wide range of people. The resulting assessment of broad categories of program functioning may have overlooked some significant areas, although the opportunity for specific comment was provided and a number of respondents took advantage of that. Data collection efforts were enhanced by the widespread community pride in the existence of the Thomas House program and the broad base of financial support. The most difficult barrier was the closing of the Rochester State Hospital and its disturbing results. This introduced a significant number of variables into what had been a stable service delivery system.

RESOURCES AND COSTS

The major expenses for this study were photocopying and postage expenses, and therefore the monetary cost was relatively small. Total staff and committee hours involved in the evaluation are estimated at 150 person-hours. Because of the volunteer nature of the program evaluation committee and the significant involvement of those committee members in other community service and professional activities, the time required for initiating, executing, and interpreting this evaluation was prolonged. However, the committee and the Thomas House board of directors are gratified with the results of this effort.

ADDITIONAL COMMENTS

This evaluation process was valuable to the committee members and the board of directors from an educational standpoint. It improved the level of knowledge that participants had about the program objectives and the operation of the program. It does seem that the effort involved in organizing, designing, producing, and carrying out such an evaluation consumed an inappropriate amount of volunteer time. If funding were available for such an evaluation to be done or coordinated by a paid professional, the board of directors and evaluation committee could obtain similar benefits with fewer volunteer hours. In a setting in which volunteer efforts and services are at a premium and need to be widely used, it would be our impression that having a professional consultant actually carry out the evaluation process with the assistance and participation of board members would be an optimal arrangement. Having volunteers performing technical tasks for which they were not trained was the weakest part of the process.

5. External Group Advocates for Better Care

Darlene Humphrey

Consumer Advocates for Better Care, Leominster, Massachusetts

SUMMARY

Consumer Advocates for Better Care (CABC) provides daily visitation to all nursing and rest homes in the north Worcester County, Massachusetts area. CABC advises residents of their rights, and receives, documents, investigates, and attempts to resolve all complaints received from residents and/or their families. In a recent case, CABC was successful in bringing to light abuses in a rest home. The ultimate result was the closing of the facility.

TYPE OF ORGANIZATION

CABC originated in 1975 when a group of elderly citizens contacted the Herbert Lipton Mental Health Center to discuss their concerns about nursing homes in the Fitchburg, Massachusetts area. They were interested in supporting legislation to improve the care provided in nursing homes, and in visiting and evaluating nursing homes. In addition they hoped to stimulate public awareness about nursing homes and to advocate for the rights of residents. In 1977, with the assistance of the mental health agency, they were awarded a grant from the Administration on Aging to become one of the six model advocacy projects nationwide. The money supported a part-time director who was responsible for program implementation, volunteer recruitment and training, preparation of forms to document investigations, and complaint resolution.

Initially two advocates were hired through the Green Thumb program (funded by the Federal Community Service Employment Act, Title V of

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the Older Americans Act) to visit area homes and to monitor the care received by residents of these homes. Subsequently, the program received funding through the area mental health agency to hire the director full time. Offices and telephones were donated by the mental health agency. In 1979, CABC became a designated nursing home ombudsman program in Massachusetts and was able to submit a proposal to the Region II Area Agency on Aging for Federal funding under Title III of the Older Americans Act. This enabled CABC to fund a full-time office, telephones, travel, supplies, etc. CABC is governed by a board of 12 community members including consumers, lawyers, and personnel from other agencies concerned with problems of aging.

EVALUATORS OR MONITORS

Presently CABC has 12 visiting ombudsmen ranging in age from 22 to 77 years. The majority of the advocates are low-income older persons who are recruited by the director and paid by either Federal Title V funds (Senior Aids and Green Thumb) or another Older Americans Act program, the Elder Service Corps, which provides small stipends for such purposes. The majority of our advocates are lay persons who have had extensive training in issue advocacy, the aging process, characteristics of nursing homes, law and aging, Medicare and Medicaid, and who receive ongoing monthly training as needed. All advocates are now certified by the state as ombudsmen. When the CABC ombudsmen began visiting rest homes, they could see there was a need to become better informed as to the special needs of elderly persons who had been deinstitutionalized from state hospitals. We contracted with our local mental health agency for training in the uses of psychotropic medications and their side effects, improving communications better with deinstitutionalized residents, and responding to their special needs.

REASONS FOR EVALUATION OR MONITORING

Residents of nursing and rest homes need interested community members to advocate for their rights since 75 percent of residents of nursing and rest homes have no family or friends to advocate for them. Regulations must be enforced and new legislation enacted to improve the lives of institutionalized older persons. Quality of care has improved somewhat because of community involvement but there is much more that the community could do to improve the lives of old people in nursing homes. Many people forget that residents of nursing homes are still part of the community.

LEVEL OF PARTICIPATION

Volunteer advocates in the CABC program function as independent and external monitors of nursing home programs.

TARGET OF EVALUATION OR MONITORING

The agency's 12 visiting advocates monitor the care received by residents of nursing homes and rest homes in 22 communities. There are 41 nursing and rest homes in north Worcester County with a total population of 1,874 residents.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

CABC advocate visits have uncovered many abuses of residents' rights ranging from complaints of cold or improper food to serious abuse and neglect. In one recent case involving a rest home, CABC advocates documented a range of abuses including lack of nutritious meals, physical abuse, withholding of medication for punishment, denial of leisure activities, and misuse of resident allowances.

TECHNIQUES USED

The technique used to monitor is daily visitation to nursing and rest homes. The visits are also used to gain the confidence of residents and to persuade them that advocates can resolve their complaints and that people in the community care. Advocates become friends of nursing home residents and residents become confident that they can share their concerns without fear of retaliation from nursing home administration or staff. Brochures are handed out to each resident and their families. Community forums and speaking engagements are conducted to educate the community as to residents' rights. CABC volunteers and staff appeared on television and radio talk shows. In 1976, CABC joined the National Citizens Coalition for Nursing Home Reform in order to have a greater impact upon national legislation. CABC's director served two terms as vice president of the national coalition.

FINDINGS OF EVALUATION OR MONITORING

Based on information gathered by CABC, the rest home cited above became the subject of litigation initiated by the Massachusetts attorney general. In its request for a preliminary injunction against the home, the Commonwealth offered the following findings regarding deficiencies:

- Failure to provide at least three daily meals that are nutritious, that meet the minimum daily food allowances set by the Food and Nutrition Board of the National Research Council, adjusted for age, sex, and activity, and that are suited to the special needs of residents, including residents on restricted or therapeutic diets

- Failure to administer medications to residents in dosages and at times prescribed by current physicians' orders
- Failure to keep receipts for all expenditures of one dollar or more made on behalf of residents out of their personal needs accounts
- Admittance of prospective residents who require medications which can be administered only by trained nursing personnel whom the rest home has not employed
- Failure to clean bathrooms, living areas, bedrooms, kitchen areas, dining areas, storage areas, attics, and cellars; and to provide all necessary cleaning supplies and materials to maintain these areas in a safe and sanitary manner
- Failure to allocate and budget funds to be used for resident activities, hobbies, trips, crafts, reading materials, and games

RECOMMENDATIONS

The attorney general's initial recommendation to the court regarding this specific case was to enjoin staff of the rest home from continuing any of the abuses outlined in the complaint.

STEPS TO ENSURE IMPLEMENTATION

CABC has testified for legislation at the State and national level. They have also informed the public about needed legislation and asked for their support. CABC also works very closely with the local legal services agency, and public health and mental health agencies. In the case of the rest home, CABC turned its information over to legal services whose staff in turn obtained depositions from aides at the home.

EXTENT OF IMPLEMENTATION

The rest home doors have now been closed and its license has been suspended. Mental health clients have been placed in other homes by CABC advocates themselves.

SPECIAL BARRIERS OR SUPPORTS

CABC's biggest barrier to the implementation of the advocacy program was, and still is, access to nursing homes. There is a bill pending at this time that would give community groups access to nursing and rest homes. Another barrier is that volunteers are very difficult to recruit. Nursing homes do not have the pleasant atmosphere one wishes they had. People are also afraid of their own mortality. They find visits to nursing homes very depressing. More community education is needed to help change these negative attitudes about elderly, infirm persons. CABC's biggest support comes from the dedicated people who work with our program. They care about the cause and have worked diligently to try to improve the lives of nursing home residents. The CABC board should be commended for the support they have given through the years.

RESOURCES AND COSTS

CABC employs a full-time director and halftime assistant and halftime secretary for a total staff cost of $26,000. Volunteer or Title V time amounts to 240 hours per week. CABC is now funded by the Region II Area Agency on Aging with Federal Title III funds. We receive $1,500 from our United Way and rely on foundation money to help defray many costs.

ADDITIONAL COMMENTS

Consumer groups such as ours must have more interest from staff members and family and friends of nursing home residents. Complaints are received in our office anonymously and we cannot act upon them. People do not want to become involved. Nursing home care will never improve substantially without involvement of the community. Hopefully, the day will come when there will be no cases submitted as serious as the one I have included in this report.

6. A Mental Health Advocacy Program Evaluates an Agency's Programs and Procedures

Nancy Sohlberg

Site Visitation Committee of the Mental Health Association of Illinois Valley

SUMMARY

The site visitation committee of the Mental Health Association of Illinois Valley (MHAIV) evaluated the programs and service delivery of the Human Service Center of the Peoria Area, Inc. (HSC). The programs monitored included: sustaining care, outpatient mental health, drug and alcohol, outreach, emergency response, and consultation and education services. Two

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residential facilities for substance abuse, a halfway house for the mentally ill, and a family home for teenage girls were included. Client satisfaction and community awareness were assessed. The site visitation committee presented a final report at a meeting with the Human Service Center executive director and the program committee and reviewed their findings and recommendations with the president and members of the board of directors of the Human Service Center.

TYPE OF ORGANIZATION

Members of the site visitation committee were recruited by the Mental Health Association of Illinois Valley advocacy chairman because of their individual skills or interest in evaluating specific mental health programs. MHAIV is a voluntary organization serving three counties. It provides programs in crisis intervention, education, and advocacy. The advocacy program, in addition to conducting site visits, has direct responsibility for advocacy to clients of the Human Service Center, The George Zeller Mental Health Center, and five area nursing homes. The organization of MHAIV consists of an executive director, a 28-member board of directors elected for a 3-year term and a professional advisory board.

EVALUATORS OR MONITORS

The site visitation committee was composed of a chairperson and 12 members. It included a psychiatrist, a professor of pharmacology, two psychologists, a counselor, three nurses, the crisis intervention chairman for MHAIV, a nursing home administrator, a health educator, a teacher, and a lawyer. None of the members were employed by the HSC. Ten were MHAIV board members.

REASONS FOR EVALUATION OR MONITORING

In accordance with its purpose as a voluntary, citizen-based, and consumer-oriented organization, the Mental Health Association of Illinois Valley and the Human Service Center of the Peoria Area signed a statement of cooperation in 1979. This authorized MHAIV to provide advocacy services for HSC clients and to conduct biannual reviews of policies, procedures, confidentiality, and utilization of data concerning the HSC's programs and services. The regional health systems agency had also expressed interest in such a review. There have been two evaluations of the HSC, in September 1979 and 1981.

LEVEL OF PARTICIPATION

Committee members were actively engaged in every phase of the evaluation. The committee requested and reviewed pertinent data, e.g., reports of the most recent site visits by the National Institute of Mental Health (NIMH), Department of Health and Human Services, and Illinois Department of Dangerous Drugs. Budgets, fee scales, procedure books, and contractual agreements with community agencies were reviewed. The committee attended an informational slide presentation given by the HSC executive director and program director and worked closely with staff and board members, arranging interviews with staff and scheduling site visits at appropriate times. They reviewed their findings and recommendations and wrote a report on each program. The reports were presented to the executive director and board of directors of the HSC.

TARGET OF EVALUATION OR MONITORING

The Human Service Center of the Peoria Area is a comprehensive community mental health center incorporated in 1976 through consolidation of a number of different agencies. The center offers a wide range of services in crisis intervention, outpatient and sustaining care, substance abuse, and education and prevention. Facilities are located throughout the Peoria area with satellite offices in neighboring communities. Other mental health services are provided in inpatient psychiatric units in two general hospitals, clinics, at the Peoria School of Medicine, and in a Veterans Administration clinic. A detoxification unit and a chemical dependency center are available. The HSC has an executive director, a board of directors, and a citizens advisory board. Peoria is a medium sized industrial city with rising unemployment.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The committee's task was to evaluate each program with respect to: intake, discharge, referral, and followup procedures; staffing patterns; modalities and goals of treatment; physical facilities and accessibility; patients' rights and client satisfaction; fee policies; staff development and attitudes; and community awareness and attitudes. An earlier NIMH evaluation had noted that the agency was not visible in the community, that the board was not familiar with the requirements for a community mental health center, and that there needed to be a full-time qualified director for the education and prevention program. In the 1979 visit, MHAIV had recommended several alterations, refurbishings, and increased maintenance at the alcohol residential center. These issues suggested areas for further evaluation.

TECHNIQUES USED

To estimate client satisfaction, a short questionnaire was distributed to the clients

present at each program site visit. Another questionnaire was mailed to two organizations: the Alliance for the Mentally Ill (a support group for the families and friends of mental patients) and Recovery (a self-help group for emotionally disturbed persons). To determine community opinion, individual letters were sent to the agencies contracting for HSC program services. Interviews were conducted with key personnel at Zeller Mental Health Center to assess the effectiveness of the sustaining care program and the appropriateness of referrals to Zeller by the emergency response service. The chief of police was contacted concerning the utilization of the emergency response service. The recommendations made by previous site visits determined our main focus. Each committee member formulated his/her own questions and designed a site visit strategy. In general, these strategies were based on the following sources: *Citizen Evaluation of Mental Health Services*, (McMurray et al. 1976), *A Trust of Evaluation* (Zinober and Dinkel 1981), and *CMHC Requirements and Definitions of States* (1980). To test board members' awareness, the chairman addressed a board meeting explaining the purpose of the evaluations and gave members a short written quiz to assess their familiarity with the CMHC requirements. The site visitation committee worked closely with the HSC program committee and invited them to go along on a visit. The site visits themselves were scheduled over a 2-week period at the following programs:

- Sustaining care
- Outpatient care
- Alcohol and drugs
- Emergency response service and status offenders
- Education and prevention program

FINDINGS OF EVALUATION OR MONITORING

The site visitation committee was generally very satisfied with the Human Service Center's services and noted considerable growth in content and scope. The high degree of professionalism, better utilization of staff, and the use of part-time staff for evening hours allowed increased evening programming without hiring a large number of additional staff. Other improvements included:

- Inauguration of a senior world daycare program that the committee felt was meeting community needs
- Establishment of a general policy for fee collection
- Improvements in the alcohol program residential services including: structural changes, improved parking, and improved interior decoration
- Hiring a well-qualified director of education and prevention and instituting a broad range of programs for professionals, clients, and the community

Client responses to the questionnaire suggested good accessibility and satisfaction with services. Community agencies responding to their questionnaires indicated a high level of trust and cooperative working arrangements.

On the negative side, the site visitation committee found that there was still a need for halfway house beds for alcoholic women; kitchen equipment and new furniture were needed in the drug residential center; and carpeting needed to be replaced in the alcohol treatment center. There was an apparent discrepancy in fees for education programs offered to the public that might make them unaffordable to some segments of the community. It was also noted that the community at large was not very responsive to providing housing for the mentally ill or geriatric daycare programs. Finally, because of a declining Federal grant, funding continued to be critical and it was vitally necessary to obtain community support for the emergency response service.

RECOMMENDATIONS

The Human Service Center was commended for its considerable progress since 1979 in the quality and scope of programs offered. The improved fee collection statistics, excellent utilization of staff, and efforts of the director, staff, and board to heighten awareness and visibility of the agency within the community were striking examples of improvement. The site visitation committee made some recommendations and suggestions in its final report. These included:

- Drug residential center should replace broken furniture, add kitchen equipment, and try to obtain some dental care for clients (The staff had also requested additional psychiatric or psychological staffing)
- Additional halfway house beds for female alcoholics and replacement of worn furniture and carpeting in the residental unit
- The director of sustaining care cited a need for better coordination with referring sources (e.g., mental health center and hospitals)
- Since sustaining care clients are usually in a low-income bracket, staff suggested a possible reduction in their fees

- Fees for education and prevention programs should be reassessed to make them more affordable and competitive
- Continued striving for better visability and credibility in the community is essential
- The declining Federal grant money makes it vital to enlist the community's financial support for the emergency response service

STEPS TO ENSURE IMPLEMENTATION

Evaluating service delivery every other year gives agencies time to respond to recommendations. Since the committee had access to site visit recommendations from the National Institute of Mental Health and Department of Health and Human Services it was able to follow up on those suggestions as well. The committee worked directly with the HSC program committee, making suggestions directly to them. A relationship of trust was established, which facilitated communication and increased the likelihood of change. The HSC director and board were very attentive and appreciative of the committee's findings and recommendations.

EXTENT OF IMPLEMENTATION

Several recommendations of the 1979 site visitation were implemented. Structural improvements in the alcohol unit increased its safety, attractiveness, and visibility. In the drug facility, safety was upgraded through physical alterations and security for medications was improved. A patients' rights statement for HSC was translated into Spanish and Vietnamese by MHAIV board members to meet the needs of the client population. An emergency personnel change was made as a result of a recommendation from the chief of police. The HSC executive director and board president took the site visit evaluation to the health systems agency and presented it at the United Way allocation hearings. Mental Health Association board members have also attended city council hearings in support of the emergency response service. Preliminary meetings between the medical director of Zeller Mental Health Center and sustaining care staff have begun. The Human Service Center recently opened new HUD housing for mentally ill clients.

SPECIAL BARRIERS OR SUPPORTS

Certainly the interest and energy invested by the site visitation committee was responsible for such a comprehensive, consumer-oriented evaluation. Further, the support and cooperation of the executive director, board of directors, and staff of the Human Service Center cannot be overestimated. The committee was not entirely satisfied with the method of reviewing records, although one member did attend record review meetings and a small number of records were reviewed. The main benefits derived from the site visits has been the increased awareness, respect, and the climate of cooperation that has developed between the MHAIV and the HSC.

RESOURCES AND COSTS

One month was required to complete the evaluation from the planning through the writing and presentation of reports. Some committee members participated in only one site visit while others contributed to two or three program evaluations. The best estimate is that volunteer time totaled 160 hours. Four days of clerical time were required to type and mail letters, questionnaires, and final reports. The cost of paper, mailing, and duplication amounted to $80 and was covered by the advocacy budget. HSC duplicated and mailed final reports to all HSC board members. Volunteer time required in the second evaluation was considerably less because of basic knowledge and skills developed during the 1979 evaluation.

ADDITIONAL COMMENTS

The Mental Health Association of Illinois Valley is very pleased to have completed two evaluations of the Human Service Center. Committee members enjoyed the learning experience, if not the actual report writing. Since the advent of the block grant system and reduction of its original grant, the HSC has had to make many adjustments in staffing and programing that will probably demand many changes in the next program evaluation. The committee urges other advocacy groups or other mental health associations to involve themselves in such an interesting and rewarding experience.

7. Mental Health Center Board Increases Involvement in Evaluation of Center Needs

Roger Strauss

Washington County Mental Health Services, Inc.
Montpelier, Vermont

SUMMARY

The standards and evaluation committee of Washington County Mental Health Services, Inc., (WCMHS) conducted an assessment of the mental health needs of the community and the capability of the mental health center to meet those needs. This project was important because it occurred during a time of budget cuts and diminishing resources. The committee members solicited information from community representatives and center staff regarding needed services and the priority for such services in case of: (1) an increase in funding, (2) a decrease in funding, (3) same level funding. The results were compiled and submitted to the full Board of WCMHS which then ranked the services according to priority. When funding projections were clarified the following year the board and the executive director were able to make decisions and plan for the future based on the findings from the project.

TYPE OF ORGANIZATION

Washington County Mental Health Services is a private, nonprofit, community mental health center with a governing board of up to 25 citizens with an interest in mental health. The function of the board is to set policy for WCMHS, to be responsible for management, and to hire and fire the executive director. Part of the board's general responsibility is to monitor programs against criteria set by others, including the Vermont Department of Mental Health, the National Institute of Mental Health (NIMH), and the National Institute of Alcohol and Alcohol Abuse (NIAAA). To do this, the board formed the standards and evaluation committee.

EVALUATORS OR MONITORS

The standards and evaluation committee was made up of both board and staff of the center, and was chaired by the executive director of the center . One of the committee members was a minister, another was the executive director of a local United Way, two were housewives, and one member was a school bus/ambulance driver. The only professional on the committee was a college teacher in child psychology. There were representatives from both line staff and administration. When the committee evaluated a program in which one of the committee members was also a staff member, that person did not participate.

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REASONS FOR EVALUATION OR MONITORING

Monitoring.--Every year the Vermont Department of Mental Health came to each center in the state to do a 3-day site visit. Sometimes as part of that visit, sometimes separate, a representative of NIMH would also make a site visit. External monitors from such organizations as NIAAA, the local United Way organization, and the local district advisory health council also made site visits.

In the early 1970's, the executive director monitored all the recommendations from the site visits to ensure they were implemented. The only input of the board was to respond to site visit reports. To increase board involvement, it was suggested that board members and staff jointly form the standards and evaluation committee which would be responsible for monitoring and evaluating programs in light of the recommendations from external monitors.

Planning.--During the 1980 Vermont legislative session the Community Services Act was passed. This bill mandated that mental health centers have a plan of service delivery available for public review. This necessitated a community needs assessment by each center. Because the members of the standards and evaluation committee had been intimately involved in monitoring programs at WCMHS, the board felt that they would be the natural team for coordinating and organizing the needs assessment and subsequent plan for the center.

LEVEL OF PARTICIPATION

Board members of the standards and evaluation committee were involved with center staff in every stage of program monitoring and planning except for interviews with community professionals. Volunteers were excluded from this task because of an assumption that community professionals would not be candid with WCMHS staff if a board member were present. In retrospect, this decision was an error. Community professionals seemed eager to participate in the

needs study and consequently a board member's presence probably would not have detracted from the spontaneous responses.

A board member on the standards and evalution team went to every program planning session to listen to staff express their ideas as to what they would do if funding increased, decreased, or stayed the same.

TARGET OF EVALUATION OR MONITORING

The assessment centered on the short- and long-term goals of WCMHS and on the capability of its program components to fulfill the needs as defined by the community. WCMHS serves a catchment area of about 50,000 residents. The area includes two small urban centers--Montpelier, which is the state capital (8,000); and Barre, a bluecollar community (11,000). A large number of clients (400) have been discharged from the State's only hospital for the mentally ill, which is also located in the county. Aftercare services to this population are, therefore, a high priority at WCMHS.

WCMHS also provides a day hospital, a children and youth service, a substance abuse program, a 24-hour emergency service, programs for mentally retarded persons, an outpatient service, and residential programs for mentally ill, mentally retarded, and autistic persons. All these programs were assessed by the standards and evaluation committee.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The evaluation and monitoring functions of the standards and evaluation committee only went into effect after a site review from an outside agency. Therefore the issues changed according to the findings of the external reviewer. Once the standards and evaluation committee took over the planning function, they concentrated on the needs identified by community representatives and program staff.

TECHNIQUES USED

Monitoring.--After a site visit, the standards and evaluation committee reviewed the recommendations of the external monitor. Members then broke up into teams of three, and each team visited each center program mentioned in the site visit report. The team reviewed the report with the program director and program staff. The first question was whether the recommendations were valid. If the program staff said the recommendations were not justified, the team would determine whether the criticisms were valid. If the team agreed with the staff, they would then act as advocates for the program with the original monitor.

If the team found that the critique was valid, or if program staff agreed with the deficiency, a schedule would be set for making corrections. The standards and evaluation team then returned to the program to see if corrections had been made. The findings of the team were reported to the committee as a whole and to the executive director.

Planning.--To begin the process, representatives of community agencies were invited to meet with the center's executive director and other appropriate program staff. At that meeting community agency staff were asked to talk about any improvements needed at WCMHS to meet future mental health needs. Minutes were sent to agency staff to document the discussions. These notes were then sent to the standards and evaluation committee and to all center program directors for distribution to staff. Committee members then interviewed program staff to determine their views of needs in light of the community input. Staff were asked to discuss ways of meeting these needs and priorities under three conditions: 1) same level of funding, 2) increase in funding, 3) decrease in funding. This information was eventually included in the community needs assessment. A public meeting was also held to secure public input. Feedback from the meeting was incorporated into the needs document that was finally presented to the entire board of directors. The board then ranked programs and approaches according to center-wide priorities. The entire planning process took over a year, from the Summer of 1980 to the Winter of 1981.

FINDINGS OF EVALUATION OR MONITORING

Monitoring.--For the most part, all site reports were favorable to the center in all programs.

Planning.--Board members were impressed with the candid responses of community professionals and their openness with staff. They were also impressed by the overall positive responses of the community agencies to WCMHS. The needs assessment coupled with the firsthand discussions with program staff gave the board an excellent overview of the demands on the center's current capabilities. It also allowed the board to estimate what more could be done under different levels of funding.

RECOMMENDATIONS

Monitoring.--All recommendations were based on site visit reports. In every instance, the board and program staff reached consensus concerning the reviewers' reports and the time limits for changes.

Planning.--The board as a whole endorsed all the existing programs at WCMHS and felt that all programs were doing important jobs. If budget cuts were in order, then two programs were

suggested for elimination. The first was a program for developmentally disabled preschoolers which provided rehabilitation and afternoon programs in their homes. It was vulnerable because, in 1981 a law was passed that encouraged local school districts to pick up preschool programs for developmentally disabled youngsters. Efforts were made to get local school districts to pick up this program, which eventually proved to be successful.

The second was a program for older persons. In Washington County similar programing was provided by three other agencies, a retired senior volunteer program, a home health agency, and an area agency on aging. Consequently, there were at least some other agencies providing services, whereas for other populations--substance abusers, chronically mentally ill, and mentally retarded--WCMHS was the major, if not only, service provider.

For the most part, the board endorsed the recommendations of the community and the staff. These recommendations can be divided into four major requests: (1) more consultation from staff; (2) more residential care for special groups such as chronically mentally ill, mentally retarded, substance abusers, and abused spouses; (3) more education and prevention programs; and (4) quicker response time in emergency situations.

STEPS TO ENSURE IMPLEMENTATION

Monitoring.--Once the standards and evalution team met with each program under review, time limits were set within which necessary changes would be made. These dates were then communicated back to the full standards and evaluation committee for approval. The standards and evaluation task force also returned later to see if the changes had been made. If not, a new date for implementation was set. It was never necessary to set a third deadline for review.

Planning.--The plan eventually became a public document and was to be used as a basis for any changes at the center. If the executive director deviated drastically from the plan it had to come before the board for review.

EXTENT OF IMPLEMENTATION

Monitoring.--A typical criticism was one from an external reviewer: "the outpatient program has a waiting list that is too long, according to Department of Mental Health criteria." After a visit from the standards and evaluation committee and a realignment of schedules and procedures, the outpatient department was able to establish a policy for seeing all clients within at least 7 days after their first call for an appointment.

Planning.--With respect to the request for increased consultation and education, it was felt that no more time could be granted these areas because of demands on the staff for direct services. Consequently, the board and staff set up a corporation called The Institute for Professional Practice. Staff who wished to work after hours for extra funds could provide courses and consultation. Cost of the courses and program would be paid by participants. Staff could make extra money and any profit would come back to the center.

Emergency teams were given backup staff who could sit with patients for long periods of time, enabling regular emergency service staff to attend crisis calls much more quickly.

The clinic negotiated with the Department of Mental Health to endorse a creative new residential program for mentally ill and mentally retarded persons. The basic approach of the program calls for placing recent state hospital patients in heavily staffed apartments. As patients are rehabilitated, the staffing pattern becomes less intense. If clients regress, the staffing pattern returns to its former level. This allows the client to stabilize in one environment as opposed to being moved through a continuum of residences, thus eliminating the anxiety attendant upon multiple moves.

SPECIAL BARRIERS OR SUPPORTS

The board's desire to work more closely with staff and to get to know them better was satisfied through the monitoring activities. For its part, the staff had a chance to work as partners with the board in the monitoring process instead of their usual role as passive recipients of an external monitoring team's recommendations. This reduced the threat of the evaluation and increased the chances that some real changes would be effected through the evaluation. The Department of Mental Health and the laws of Vermont provided external support for the planning process. The major barriers were the time it took for staff and board to participate.

RESOURCES AND COSTS

For both staff and board, the time spent in a typical year on the standards and evaluation committee was 16 hours. This included regular committee meetings, which lasted about 2 hours each, and the task force time spent reviewing the site visit reports with each program. Board member time on the planning process was much less since they were not involved in the many interviews with the community agencies (approximately 5 hours each).

ADDITIONAL COMMENTS

The staff liked the interaction with the board because they felt they got to know them much better and they also felt themselves involved in an important activity of the center. They realized

adversary. Given the board's advocacy role, such a perception may sometimes be unavoidable. However, problems can usually be worked out by keeping channels of communications open and in constant use.

TARGET OF EVALUATION OR MONITORING

The Manhattan Children's Psychiatric Center is one of six State-run children's centers in New York State. It was officially opened in 1972.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

In addition to their responsibilities for monitoring ongoing services, the MCPC board undertook to respond to staff complaints from numerous professionals and child care personnel regarding various aspects of the institution's functioning. Such concerns had been growing since the appointment of a new director about 2 years after the board was established. The airing of staff grievances was facilitated when, after continual urging by the board, notice of its meetings was posted (board of visitors meetings are open meetings, which are supposed to be posted and published in the community).

Another issue arose early in the MCPC board's experience when members were asked by a concerned parent to conduct an investigation into an alleged instance of child abuse on one of the wards. The board was also asked to respond to allegations by a previous employee of mismanagement and incompetence in the administration of the center.

TECHNIQUES USED

Board members must be thoroughly familiar with their particular institution, and are therefore required to visit and inspect the facility at least twice a year--though, in fact, most members do this far more often. The board's assessment of conditions at the facilities and their recommendations are sent directly to the Governor and the State's Commission on the Quality of Care. In addition, boards have statutory powers to:

- Investigate all charges against the director and all cases of alleged patient abuse of mistreatment made against any employee
- Interview patients and employees of the facility in pursuit of such investigations
- Subpoena witnesses under oath, and require the production of any books and papers deemed relevant to the investigation

The results of investigations related to the facility or its management are reported directly to the Governor and the Commission.

An important part of the job of a board member is becoming familiar with all aspects of the facility, including the physical plant, the clients, and the staff. This necessitates frequent site visits, and establishing an accessible presence by talking to patients and staff. Though there may be an initial reaction to a board member as someone who is "snooping" or acting as a secret agent, board members should make clear that the focus of their interest is the quality of care and treatment at the facility and that they welcome the assistance of staff, patients, relatives, and all others who can identify areas where improvements can be made as well as point out achievements for which the facility should be congratulated.

The board at MCPC began its work by asking for various kinds of documents detailing the past history and present operation of the center, and received a wealth of material. However, this did not include a report by a former employee who had complained of various practices at the facility which he felt were evidence of mismanagement and incompetence. Having heard about this document from outside sources, the president of the board requested a copy from the regional Office of Mental Health (OMH). Upon learning of this, the director of MCPC took great offense and accused the board of going behind her back, looking for negative material, and so forth. As a result, the board learned early in the process of the necessity for any "watchdog" group to be clear and direct about its activities, its channels for access to the materials required to carry out its work, and the necessity to use other channels available only after it is apparent that it is impossible to obtain such information directly and openly.

FINDINGS OF EVALUATION OR MONITORING

With regard to the issue of staff and administrative conflicts, the board had to emphasize continually that their concern was the quality of care and treatment provided, and that they were not responsible for, nor capable of, running the facility. The board could act as a conduit for staff concerns, they could direct grievances toward appropriate channels (such as issues of evaluation and promotion, which were union concerns), they could investigate some staff concerns themselves (abuse of overtime, lack of structured followup to problems raised in committees, absenteeism, increased incidents, etc.), and they could report to the director of MCPC, the OMH and the Commission on the Quality of Care on the results of their inquiry.

In response to allegations of abuse, two members of the board with experience in the child care field spent several days at the facility reviewing records and talking to staff, concluding that there had not been actual abuse, but that

staff had not been sufficiently trained in techniques for handling difficult residents.

RECOMMENDATIONS

Handling the issue of staff dissension and rebellion is particularly touchy, and the board was extremely careful to stress their concurrence with staff concerns regarding patient care and the functioning of the institutions. However, the board emphasized that they were not in a position to take sides.

On the abuse question, the board recommended that staff receive training in the handling of acting-out patients, and noted that the line of responsibility and authority on that ward had to be clarified. These recommendations were shared with the administration.

STEPS TO ENSURE IMPLEMENTATION

Continued monitoring by the board ensured that recommendations would be followed up.

EXTENT OF IMPLEMENTATION

Not applicable.

SPECIAL BARRIERS OR SUPPORTS

The major area where the MCPC Board has had difficulty is in reaching parents of those served by the center and establishing communication with them. In fact, though there have been some replacements on the board over its almost 4 years of existence, an effort has been made to keep one of the seven slots open so that it may be filled by a parent or relative of a child currently at the institution. The effort has thus far been unsuccessful.

A potential area of difficulty facing oversight bodies is the necessity to establish independence as a monitoring body along with the necessity to form a mutually constructive working relationship with the administration of the facility. The possibilities of being "co-opted" by the director in order to avoid an adversarial stance, or of falling into a pattern in which confrontation is the primary mode of communication, both exist. It is not always easy to walk the line between these two patterns, and indeed confrontation may become necessary in certain situations.

RESOURCES AND COSTS

The board receives no salary. Its costs in connection with board duties are reimbursed.

ADDITIONAL COMMENTS

Citizen advocacy is essential in our society with so many competing, although worthy, causes and with so many enormous bureaucratic structures to negotiate and influence. Advocacy for children is especially important since traditionally the young have not had a strong constituency to press for better, more adequate, and appropriate services. In the arena of institutional care of the mentally disabled youth of New York State, the boards of visitors have made and continue to make their voices heard on behalf of these youngsters, and are working together with others whose goals are similar--in the system and outside it.

9. Advocacy Organization Sponsors Board and Care Survey

David Schott

Mental Health Advocacy Project of the Santa Clara County Bar Association Law Foundation, Inc.

SUMMARY

In 1981, the Mental Health Advocacy Project (MHAP) of Santa Clara County, California, sponsored a survey of all of the board and care facilities in the county serving mentally ill and developmentally disabled adults. In order to collect information about the homes, MHAP recruited student and consumer volunteers to interview board and care residents. The result of the survey was the preparation of a guide titled *Catalogue of Residential Care Facilities in Santa Clara County*. In order to make the catalog accessible to a wide range of clients, symbols of various aspects of the homes such as food, physical plant, and atmosphere were developed. The biggest problem encountered by MHAP was gaining access to board and care homes because of the resistance of the operators. Over all, the project showed that board and care residents can make judgments about their circumstances and can use information to make decisions about their care.

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TYPE OF ORGANIZATION

The Mental Health Advocacy Project was

organized in July 1978 under the sponsorship of the Santa Clara County Bar Association Law Foundation. Initial funding for the project was provided by a grant from the American Bar Association Commission on the Mentally Disabled. MHAP focused its activities on the reform of the mental disability system through direct case representation of clients, as well as impact litigation on behalf of mentally ill and developmentally disabled clients. The project, which is located in the center of San Jose's board and care community, has expanded its program and now receives funding from multiple sources including a contract with Santa Clara County to provide advocacy services. The project outlined in this case was supported by a $25,000 program development grant from the State Department of Developmental Services.

EVALUATORS OR MONITORS

The assessment of board and care facilities was undertaken by an independent team that included MHAP staff, ten undergraduate social work students from San Jose State University, and three consumers of board and care services. In order to recruit the social work students, MHAP staff made a presentation to a class detailing why the students should fulfill their community involvement requirement by working with the advocacy project. The consumers were recruited by word of mouth among the board and care residents in the vicinity. Consumers' reactions were also solicited by questionnaire.

REASONS FOR THE EVALUATION OR MONITORING

Prior to this project, few sources of information regarding board and care facilities existed in the county, and those that did--such as a reference guide prepared by the Residential Care Association--were written by, and for professionals or providers. MHAP staff felt that it was important that the client perspective on the adequacy of board and care facilities be solicited. In order to support this activity, MHAP staff applied for a grant from the State to help board and care residents to become more active as consumers of service. The notion of compiling client assessments of facilities into a catalogue did not emerge until the project was underway.

LEVEL OF PARTICIPATION

MHAP staff were involved in the evaluation at all stages of the process. They recruited the students and consumers, participated in the design of the board and care survey, conducted training sessions, assigned homes to surveyors, maintained periodic contact with the volunteers, met with a variety of interest groups to facilitate access and to ease political problems, assisted in the ratings, and wrote up the results. Consumers and students conducted the onsite surveys and contributed to the final ratings.

TARGET OF EVALUATION OR MONITORING

The objective of the survey was to derive ratings on all board and care facilities serving mentally ill and developmentally disabled persons in Santa Clara County. Homes serving alcoholics, drug abusers, senior citizens, or children were excluded from the assessment. Homes surveyed varied from 2 residents to 45-50, though the majority housed between 15 and 25 persons. Approximately 80 percent of the homes assessed were for-profit organizations. Of the total number of homes targeted, surveyors were able to develop ratings on over 75 percent. In order to maintain the credibility of the survey, staff excluded homes from the ratings where the surveyors were unable to contact a large enough sample of residents. In many instances, inadequate sample size was the direct result of an inability to gain access to the home.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The board and care assessment focused on five aspects: food, the quality of the physical plant, and atmosphere of the home (i.e., the extent to which it was homelike or institutional), the fairness of the house rules, and the extent to which residents were encouraged to be independent.

TECHNIQUES USED

The first step in the assessment was the design of a questionnaire. Once a draft had been prepared, MHAP staff conducted a field test using a group of consumers of whom roughly one-third were current board and care residents, one-third were former residents, and one-third had never been in board and care facilities. Based on the results of the field test, revisions were made to the questionnaire. The questionnaire was structured to elicit short answers, but residents were also given the opportunity for open-ended responses. The next step involved training the students and consumers in administering the questionnaire and also providing an orientation to board and care facilities. Followup meetings were held with the surveyors to clarify any questions and problems regarding the questionnaire.

Incidentally, interviews with board and care residents were conducted by teams made up of students and consumers. Eventually, consumers were able to conduct interviews on their own. By and large, residents were interviewed onsite at times when they were likely to be at the home (e.g., around dinner time). Whenever possible, residents were interviewed privately, although

this was not always possible. If the operator would not grant access to the interviewers, they canvassed day programs to identify residents of particular homes. Gaining access to some board and care facilities proved to be the biggest problem at this stage of the assessment.

Upon completion of the survey, MHAP formed three-person teams to develop the ratings for each facility. Teams developed consensus statements for each facility (e.g., if 8 out of 10 residents said the food was very good, then the consensus statement read, "most of the residents say the food is very good"). The result of this process was a one-page digest of responses per facility that reflected the average rating of the residents or the consensus of those contacted. At the top of each page, the operator of the home was given an opportunity to describe his or her facility. MHAP also offered the operators an opportunity to prepare a rebuttal to resident ratings and to have the rebuttal included in the catalogue. However, none of the operators took advantage of the opportunity.

In order to make the guide as accessible as possible, MHAP staff spent time designing and field testing symbols that could be understood by semiliterate clients. For instance, the symbol for food was a plate and silverware and the level of the rating was indicated by one to four stars underneath the food symbol.

FINDINGS OF EVALUATION OR MONITORING

By and large, board and care residents tended to rate their facilities fairly highly. This is not surprising, given the fact that research has consistently shown that mental health clients tend to express satisfaction with services received. In those few instances where residents made highly critical comments, MHAP staff required that some other evidence be available before the information was included in the catalogue.

RECOMMENDATIONS

Based on the experience gained during the survey, MHAP staff are convinced that board and care residents can participate in decisions regarding their surroundings. They neither lack the judgment, nor--as some family members maintained--are they harmed by taking responsibility for decisions about their place of residence. Further, given the problems that some surveyors had in gaining entry, project staff strongly support provisions that guarantee free and open access to board and care facilities and residents.

STEPS TO ENSURE IMPLEMENTATION

The completed guide, titled *Catalogue of Residential Care Facilities in Santa Clara County,* was advertised to several newsletters and copies were made available in the MHAP office for persons who wished to examine it.

EXTENT OF IMPLEMENTATION

To date, several consumers have come to the MHAP office to consult the guide, but only five copies have been distributed. In part, the limited circulation is attributable to a shortage of funds for reproduction and also to the fact that some of the material is now dated. Requests for information regarding the guide and the assessment process have been received from around the State, but it is not clear whether similar assessments have been conducted as a result. MHAP staff have not advertised the availability of the guide among county casework staff on the assumption that they have their own sources of information.

SPECIAL BARRIERS OR SUPPORTS

The major barrier to the board and care assessment was securing access to board and care residents. Operators of the homes were, in some instances, extremely reluctant to let surveyors into the homes since they were fearful that the results of the survey might damage their reputation. In order to overcome the resistance of the operators, MHAP staff met with the providers on numerous occasions. Ultimately, advocacy staff worked with the State licensing agency and others to secure an interpretation of the law that allowed access to board and care residents if the residents wanted to talk to the surveyors. Eventually, surveyors were able to gain access to most homes, and where they were unsuccessful, they sought out residents in day programs.

Another group that expressed disagreement with the aims of the project was a vocal minority of the local parents organization. These parents argued that mentally ill and developmentally disabled persons should not be permitted to make judgments regarding where they should live without the supervision of mental health professionals or family members.

Groups in the county concerned about the project, including board and care operators, providers, parents, and the county board and care consulting unit, approached MHAP and suggested that they form an advisory body. MHAP agreed and met with the groups at least seven times during the course of the assessment. At the beginning, the advisory group wanted more control over decisions regarding the survey but MHAP staff ultimately maintained control over the project.

On the positive side, MHAP staff point to the consumers advisory group as a supportive body during the conduct of the survey. This group was

autonomous since the consumers were worried that their viewpoints would be overidden in the professional advisory group. MHAP staff also noted that the county mental health association was supportive of the project.

RESOURCES AND COSTS

The project required the time of approximately one full-time MHAP staff member for 1 year. After that time, MHAP staff were involved periodically until the document was completed. Volunteers spent 10 hours in training, 30 hours in interviewing, and another 10 hours developing consensus statements and tallying data. The grant for the project was $25,000. The project took approximately 18 months from beginning to end.

ADDITIONAL COMMENTS

If such a project were to be conducted again, MHAP staff suggest that funds for publishing the catalog be built in from the beginning, and that problems of access be dealt with from the start. They also suggest that the advisory committees be formed at the project's inception. With respect to interviewing, it is suggested that wherever possible clients be interviewed privately. This point also suggests that more attention be paid generally to the circumstances under which clients are interviewed in order to garner the most responsive results. Finally, attention should be paid to ensure that the information is current when the guide is distributed, and that an inexpensive method for broad distribution be devised.

10. Patients Group Evaluates Care

Gabriel Manasse in consultation with Charles Gold

Brentwood Veterans Administration Medical Center, Los Angeles, California

SUMMARY

The Patients Advisory Consultation Team (PACT), organized in 1973, is a volunteer group composed of patients at the Brentwood Veterans Administration (VA) Medical Center who provide feedback from the consumer's point of view. PACT's functions include preparation of an annual report for the director of the facility citing the strengths and weaknesses of the institution; and representation on the clinical and administrative executive boards; and membership on the dean's committee--an executive group linking the medical center with the University of California at Los Angeles. PACT also serves as a primary recipient of complaints and investigates such complaints for the medical center. In the summer of 1981, PACT also organized a national conference focused on "Patient/Staff Cooperation in Psychiatric Care." Major concerns of the group over time have included discrimination against mentally ill persons, inadequate housing in the community, shortage of rehabilitation services, and individual client rights.

TYPE OF ORGANIZATION

PACT is a group of patient volunteers. It is open to any patient at Brentwood VA Medical Center whether inpatient, outpatient, or even those who have ceased formal therapeutic relationships. One staff person is currently a regular member, and staff have often served as consultants. Since its inception, this group has been part of the administrative structure of the Brentwood VA Hospital. Inclusion in that structure, with direct links to the director of the center and the education service, were considered crucial by the volunteer patients who proposed the establishment of PACT.

EVALUATORS OR MONITORS

Regular members of PACT are all active or former psychiatric patients. Their backgrounds are quite varied. The current president of PACT was a carpenter prior to his physical, and later, psychiatric impairment. Others have been merchants, workers in various industries, teachers, etc. Tasks are assigned by the group in accordance with its assessment of the volunteer's capabilities.

REASONS FOR THE EVALUATION OR MONITORING

The evolution of the PACT idea was rather serendipitous. Initially, a small group of volunteer patients was assembled in an attempt to get their suggestions for the development of a new acute treatment program. It soon became evident that the volunteers had little to offer to the design of a new treatment program per se, but were able to identify major institutional issues that had traditionally remained unaddressed or insuffi-

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ciently addressed. Including client perceptions as an ongoing part of institutional assessments seemed higly desirable. The hospital director was petitioned to establish the group with those purposes in mind. The ability of this group to evaluate patient complaints was discovered and led to the creation of the Patient Staff Treatment Review Board (PSTRB).

LEVEL OF PARTICIPATION

The level of involvement of PACT varies according to the issue involved. PACT submits an annual list of recommendations to the director which is based on the perceptions of the collective group over the year. The list notes the strengths and weaknesses in the functioning of the medical center. Various members sit on policy groups and provide ongoing consultation. Moreover, members are frequently appointed to task forces in order to investigate particular issues.

Patient complaints are also brought to the group. The type of complaint determines the steps that will be followed. Frequently the organization assigns a member to look into a situation and give a report. Where it is appropriate, hospital authorities may be involved.

TARGET OF EVALUATION OR MONITORING

Brentwood VA Medical Center is a psychiatric institution providing care to veteran patients in the Los Angeles area. The fundamental focus of PACT's attention has been on this particular institution and its programs. Late in 1981, this institution was merged administratively with the medicine/surgery sister institution, Wasworth Medical Center. Negotiations are currently underway to define the relationship of PACT to this new entity.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Over the course of the years, many different types of issues have been evaluated by PACT. Problems in the administration of support services have been a frequent focus. For instance, problems in checking in or retrieving clothes from the personal effects section formed the basis for one major project. Obtaining placement of a pay telephone in an area accessible to a sometimes locked ward was another project. Additionally, PACT has also been active in increasing public awareness of the difficulties of finding adequate housing, supporting patients and trying to deal with discrimination against psychiatric patients in the community, helping patients become aware of benefits to which they are entitled, and reviewing patient complaints. The latter can range from disputes about treatment (most commonly disputes about discharge planning) to questions of privacy and even cases of alleged patient abuse by staff. An ongoing issue is the need to divert more of the center's resources into rehabilitation efforts rather than acute treatment. There has been less focus on the physical plant. At times apparent institutional deficiencies have been worked on directly by the group. For instance, at one time PACT ran a nightly social club for inpatients and outpatients.

The focus of the patient/staff conference held in June 1981 was on the limits of treatment imposed by the state-of-the-art in psychiatry and its traditional deemphasis of patients concerns. This issue was addressed from the perspective of the chronically mentally ill. Since the conference was generated by a VA patient group, much of the emphasis was on VA programs.

TECHNIQUES USED

Generally speaking, problems are brought to the attention of PACT through first hand reports from persons involved. Patients who report inadequate or incorrect treatment can demand that the PSTRB be convened. This group, consisting of four senior staff and three patients, reviews disputed treatment decisions and has the power, with the concurrence of the hospital director, to overrule the treatment team's decision. As a rule, an investigation is conducted either through interviews with other parties, or--if there is a dispute--by gathering information on a particular situation. For the first 8 years, meetings occurred twice weekly. Now the group conducts one business meeting weekly. The other meeting time has been devoted to a new project, holding orientation sessions for first-time admissions to the medical center.

The most important activity of the team is the maintenance of accessibility. PACT can be contacted by telephone or a visit to their offices during normal working hours. In some instances, for particular issues, PACT has utilized surveys. For instances, a survey on the adequacy of services to female veterans was prepared and conducted by PACT in conjunction with staff.

In order to dramatize client concerns, PACT organized a national conference titled "Patient/ Staff Cooperation in Psychiatric Care" in 1981. Patients, prominent VA staff from around the country, and community leaders met for 2 days to discuss policy questions developed by PACT.

FINDINGS OF EVALUATION OR MONITORING

There is no simple way to define findings that span 9 years. Speaking generally, there has been a sense that intervention focuses more vigorously on acute care than on chronic care and rehabilitation. (This is not perceived as institution-specific, but as characteristic of the field in general.) Clients feel that care of the residual illness and rehabilitation ought to be emphasized. Clearly there are many social issues

that confound treatment: inadequate housing, discrimination in the community, poor public transportation, etc. These make all the attendant problems of mental illness much more severe.

On the other hand the group is greatly pleased by the support it has found in the administration of the medical center and the medical center, in turn, has been generally pleased with the work of the group. The interactive dialog between the staff and patients is perceived as healthy from both points of view.

RECOMMENDATIONS

The general trend in recommendations has been toward increased emphasis on rehabilitation and care for the chronically ill as opposed to acute care. There also has been a strong wish to increase attention to the physical needs of the psychiatric patient, a desire which may be partially realized through the current merging of facilities.

A major recommendation of the group has been that other institutions encourage similar patient groups. Many problems have been resolved by this group in a way that is believed to be highly preferable to traditional means.

STEPS TO ENSURE IMPLEMENTATION

Generally the relationship with the medical center has been cooperative. There is little that the group can do to enforce its recommendations but they have had the support of the administration in an overall sense and most recommendations have been influential, even if not wholly adopted. The only way to further ensure adoption is to monitor implementation over time. This has been done over the course of 9 years.

EXTENT OF IMPLEMENTATION

The general stance of the administration towards psychiatric patients has greatly improved over the course of 9 years. A new awareness of the needs of the chronically mentally ill has seemingly emerged and inclusion of patients in many policymaking bodies gives testimony to the institution's respect for client views. Of course, the PACT voice is only one of many, and their perspectives have not been entirely adopted. The working relationship, however, remains sound.

SPECIAL BARRIERS OR SUPPORTS

A constraint, which is inevitable in this type of arrangement, is that many of the patients are in active treatment with members of the staff. Clearly this leaves them partially restrained in their critical evaluations. Nonetheless, by forming this type of group, residents have provided support for one another, and judging by reaction of the administration, the evaluations on the whole have been honest and open. The major support for the activity is provided both by PACT and the hospital administration.

RESOURCES AND COSTS

There are no paid staff who have participated in this activity in a regular fashion. A small amount of money has been allocated for supplies although most supplies have come through voluntary donations. The hospital provides some housekeeping services, has allocated a small unused building to PACT, and allowed a telephone to be installed for the group's use. A small band of dedicated patient volunteers contributed enormous amounts of time over the last 9 years to ensure the group's continued functioning. Resources for the conference hosted last year came mostly through donations; a small amount was supplied by units of the VA, some services were donated by the University of California, Los Angeles, and many persons attended on their own time.

ADDITIONAL COMMENTS

The PACT group remains viable and valuable. However, there are chronic problems in recruiting new persons to take on the burdensome and time-consuming tasks. Conceivably, it could be desirable to pay some of the patient volunteers for their time, although difficulties in arranging stipends might outweigh the benefits that could be achieved.

How Much Will You Be Involved?

After Doug and his committee have discussed the mental health association's organizational strengths and limitations, the conversation turns logically to a discussion of the level of involvement that the evaluation committee should have in any information collection and planning activity.

Since Doug has already secured an agreement from the committee that they will take a fairly active role in the evaluation project selected, he suggests that they have therefore ruled out serving as citizen responders to someone else's evaluation. The question, then, is whether the committee will conduct the study independently, work in partnership with the county, or bring in an outside consultant.

Though the association has a good working relationship with the county department of mental health and the county advisory board, the interests and priorities of these two groups differ, at least for the time being, from the interests of the mental health association. The advisory board is in the midst of assessing prevention programs in the county, and the county department personnel are currently going through a major reorganization. Further, a collaborative evaluation would to some extent hamper the committee's ability to be critical of county planning practices--an issue that the mental health association feels strongly about.

The factors in favor of conducting an independent evaluation include the association's reputation and past accomplishments. Two years ago, the association conducted an independent evaluation of children's services that resulted in major reforms at the county level and that became a model statewide. During the course of the evaluation, the association garnered significant respect from the mental health and generic human services agencies in the county. An independent evaluation would also mean that the committee could collect information that would be useful to the internal needs of the association as well as to the system as a whole. Finally, since there are some tensions between local county staff and State staff, maintaining independence from the county would free Doug and his committee from any unnecessary political baggage.

The committee decides to work independently for the reasons discussed above, and they now have to determine to use an outside consultant to assist with the project. Two factors influence this decision. First, the association, like many voluntary organizations, does not have any discretionary funds and would have to seek foundation support to pay a consultant. Second, Doug feels strongly that the association volunteers should conduct the study in order to become more familiar with the system. The committee therefore decides to conduct an independent evaluation.

The cases in the following chapter cover various levels of involvement of citizens and consumers in evaluating and monitoring mental health and related services. The spectrum ranges from citizen participation as respondents to key informant surveys to totally independent monitoring and evaluation projects conducted by citizens.

Subjects of Evaluation

In case #11, Donald Eib describes a joint venture sponsored by a mental health center, a health systems agency, and a State university. The evaluation, which was aimed at the development of a long-range mental health plan, utilized personal interviews with local citizens as the core of the needs assessment portion of the project. Though citizens were not involved in the design of the project, their views were considered critical by the groups involved.

In the next case, written by Suzan Wolpow, consumers are used as the subjects of evaluation, although in this instance they play a more active

role than the citizens in the above case. The consumers are clients of a psychosocial rehabilitation club and are participants in an agencywide evaluation. They in fact helped to structure the evaluation questions and also reacted to the results. Their participation was critical given the consumer-oriented nature of the agency.

Solicited Reactors

In case #13, written by Lois Burgner, citizens are used primarily as reactors to evaluation materials prepared by a mental health center. The citizen/consumer team, called a citizen review group, reviewed agency materials, evaluation results, and other relevant documents in order to develop recommendations for center administrators. The review group included consumers of services and their families and representatives of agencies in the community that utilize center services. According to the author, the citizens and agency representatives made practical and responsive recommendations and all concerned seemed pleased with the process. Though the use of citizens and consumers as reviewers of evaluation results is certainly beneficial, this case shows two of the possible weaknesses of this approach--diminished consumer interest and involvement over time, and a lack of commitment on the part of the center board and administration, at least initially, to carry out the recommendations of the review group.

Partners in Evaluation or Monitoring

The subsequent three cases describe citizen evaluations conducted in partnership with public mental health groups. Case #14, written by Barbara Geddie, describes a cooperative arrangement between a State mental health association and a State department of mental health. The arrangement involved the placement of an association member on each site-visit team conducting reviews of service monitoring around the State. Ms. Geddie points out the benefits of having citizens serve on site-review teams, including the fact that citizens bring a certain sensitivity to client-related and community-related issues and that citizen team members are able to advocate for program expansion in ways that other team members are not. Further, information gained by citizens during the review process is valuable to the mental health association in designing its lobbying strategies.

The next related case, prepared by Diane Rich, involves a multiple partnership--a State mental health association, the State mental health agency, and the Federal regional ADAMHA office. This activity also involved site visits to mental health providers around the State in a review process that integrated both State and Federal requirements. In this project, State and Federal officials had to be convinced of the value of citizen participation, but as time went on these same officials became reliant on the citizens for the perspective they brought to the monitoring activity.

In the final partnership case, Jean Fiore describes a joint review of a county's emergency services conducted by the county advisory board in conjunction with county mental health and human services agencies. The partnership--which included the provision of technical assistance and other in-kind support--proved beneficial to the citizen group since the development of survey instruments turned out to be a very complex task. The partnership also tended to ensure an audience for the results.

Independent Evaluators of Monitors

All three of the next cases involve citizen or consumer groups that conducted or are conducting independent evaluation or monitoring activities. The first example, written by Ellen Colom Deacon and Thomas M. Quilter, reflects the joint efforts of a county mental health association and consumers of services from the area. The study was initiated by the association in order to gain citizen assistance in the development of an advocacy system and to develop a better understanding of the consumer view of mental health needs in the area. Using the nominal group technique, facilitators worked with a group of mental health consumers to identify priorities for service improvement. The association also conducted interviews with current and former consumers. By conducting an external or independent assessment, the association was able to collect information that was both useful for its own internal planning purposes and also for its larger system reform agenda.

Case #18, written by Rita T. Parle, involves an ad hoc citizens body appointed by a mental health board of trustees, but which functioned in a totally independent fashion. The study committee was created as a result of controversy surrounding the management of the area's mental health center. Given the nature of the problems uncovered by the committee, which included conflicts of interest, previous mismanagement, and nepotism, it is hard to imagine that a group working in partnership with the agency could have had the freedom to explore these problems.

The last case in this category, written by Christine Anderson, Michele Bollenbeck, and Iris Freeman, describes the activities of an independent citizen advocate group working with elderly persons in nursing homes. The case poignantly portrays the ways in which individuals can have an impact on the lives of vulnerable persons at risk of abuse or neglect. It once again emphasizes the importance of routine monitoring of nursing home facilities--especially for the consultation of individuals with no other family or friends.

External Consultant

The final case in the chapter describes a collaborative evaluation effort that involved a professional evaluator and volunteer evaluation team members. The case clearly indicates the ways in which volunteers--in this instance, professional volunteers--can augment the resources of an external consultant and also provide him or her with important insights and specialized expertise.

11. Citizens as Subjects of Evaluation

Donald J. Eib

Newaygo County Mental Health Center

SUMMARY

The board of directors of the Newaygo County Mental Health Center (NCMHC), as part of the development of a planning system, undertook a three-part project: (1) a basic study for long-range planning; (2) the development of a long-range plan from an internal perspective; and (3) conduct of a needs assessment through interviews with knowledgeable persons. The project addressed both internal and external views of the agency, and also provided linkages between a university, a health system planning agency, and the center.

TYPE OF ORGANIZATION

The Newaygo County Mental Health Board is comprised of residents of the county appointed by the Newaygo County Board of Commissioners. The board sets policy for the operation and delivery of services to the mentally ill and developmentally disabled residents of the county.

EVALUATORS OR MONITORS

This study was conducted by a student intern in policy and planning, as a second year M.S.W. placement. The agency provided a stipend and summer employment to the student. This individual developed a design for the study in association with planning staff from the regional health systems agency (HSA).

REASONS FOR THE EVALUATION OR MONITORING

The Newaygo County Mental Health Center was established in 1972. Several attempts at developing a comprehensive planning system have been made since that time. The NCMHC subscribed to the concept of the "balanced service system" standards of the Joint Commission on Accreditation of Hospitals (JCAH 1979). The JCAH standards address issues of planning and consumer involvement. This concept, along with a long-term need of the board for a well-organized planning effort, brought the project into focus. Incidentally, the university's school of social work needed a student placement, and the regional HSA, which has several rural community mental health programs in its service area, needed a model plan. The convergence of these three needs meant that all agencies could benefit from a cooperative effort.

LEVEL OF PARTICIPATION

As noted above, the evaluation system was a cooperative effort among three agencies. The entire staff of the center participated in the long-range planning, as well as providing information to the individual (student) who conducted the interviews with key informants (knowledgeable persons). Citizens were the subjects of evaluation since their views of service adequacy were at the heart of the study.

TARGET OF EVALUATION OR MONITORING

This project focused on the total agency. The Newaygo County Center is the sole service provider of mental health and developmental disabilities services in a rural county with a population of only 34,000. The poverty level is high, and the unemployment level in good economic issues is in excess of 10 percent, and is currently over 25 percent. The agency provides a full range of CMHC services including outpatient, partial hospitalization, case management, 24-hour emergency services, prevention, family crisis services, and day programs. The center is also licensed to provide outpatient substance abuse services.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The survey of citizen concerns posed the following questions:

- What kind of mental health services does your community need?

For further information write Donald J. Eib, A.C.S.W., Director, Newaygo County Mental Health Center, 1049 Newell Street, P.O. Box 8367, White Cloud, MI 49349, (616) 689-7330.

- What kind of mental health services might your neighbors need?
- What kind of mental health services might your family/relatives need?
- Describe the services currently available from the Newaygo County Mental Health Center.
- How would you like the services delivered?

TECHNIQUES USED

Forty key informants were selected and interviewed. Because the center was just starting to gather planning information, it was considered best to proceed in a very general manner, focusing on a broad area of citizen concern which could be expanded in later assessment efforts. Key informants were selected on the basis of area of residence, sex, religious affiliation, age, race, economic status, length of residency in the county, and national origin. One individual conducted all of the interviews, most of which were held in the informant's natural setting (i.e., workplace, home, etc.). It was felt that the combination of a personal interview, with open ended questions, maximized the latitude of responses.

FINDINGS OF EVALUATION OR MONITORING

Two major areas were found to be concerns in the key informant responses. These included the agency's need to increase and expand public education and information efforts, service delivery, and the possibility of establishing agency branch offices.

RECOMMENDATIONS

One recommendation was that the center should improve communications with the community through increased efforts in public information and education.

A second recommendation supported the expansion of the center through multiple sites and modes of delivery. Specifically, satellites and additional group counseling services were suggested. Respondents persistently commented on the need to reach more people with the resources available.

STEPS TO ENSURE IMPLEMENTATION

The recommendations were made a part of the NCMHC's long-range plan which is reviewed on a regular basis by the agency's administration, the program committee of the board, and, finally, the full board. The extent of achievement of long-range goals in the plan is published for internal and external review every year.

EXTENT OF IMPLEMENTATION

On the basis of this study, public information activities have increased by 50 percent. Because of limited funds, implementation of the suggestion that services be expanded on a decentralized basis has not been fully implemented. However, services provided to agencies such as public schools have changed in orientation from consultative to more direct service.

SPECIAL BARRIERS OR SUPPORTS

The process of development and implementation of the study met with limited resistance. There was a remarkably high level of response from key informants, with only one respondent refusing to participate in the study. The study received full support from the staff, board, and administration

RESOURCES AND COSTS

NCMHC is a small agency, serving a rural catchment area. Fiscal resources are limited, as well as expertise for the development and implementation of such an evaluation. As a result, the resources of a university, the HSA, and the center were combined to provide needed information to each of the participants. The total cost for the project was $9,000, which included a stipend for the student study director, a project design by university staff preceding the initiation of the project, travel, and other costs.

ADDITIONAL COMMENTS

By utilizing the resources of the HSA, the university, and the available fund of the center, the project was able to meet the needs of all cooperating organizations. The HSA has a model plan for distribution to other mental health boards in their region, the university secured a placement appropriate to the educational needs of the school of social work, and the NCMHC Board has as a final product a plan that integrates both internal and external concerns.

12. Consumers Offer Feedback on Social Club Functions

Suzan Wolpow

Center Club, Boston, Massachusetts

SUMMARY

In the Spring of 1982, an evaluation of Center Club, a psychosocial rehabilitation club for former psychiatric patients, was conducted. The purpose of the project was to evaluate club member satisfaction with Center Club services and program components, as well as to identify club member needs. Evaluation questions were generated through a series of discussions involving the evaluator, club members, and staff. The questions elicited information on the overall functioning, needs, and goals of Center Club. The survey was administered by members and staff to all club members attending the program during a 10-day period. Results were compliled and reported by the evaluator and are presently being reviewed for implementation by a committee of six club members and one staff member.

TYPE OF ORGANIZATION

Center club is a 23-year-old psychosocial club with a primary focus of meeting the social support needs of former psychiatric patients in the community. The club is part of Center House, Inc., a comprehensive agency that offers multiple services to former psychiatric clients. It is a nontreatment setting with no psychiatrists or psychologists on staff. Rather than being placed in a patient role, club members join in a social club setting where they can participate at whatever level they choose. Center Club operates 7 days a week on the third floor of a "Y" in downtown Boston. It offers a wide variety of both regular and fluctuating programs. The center's prevocational program includes components of maintenance and housekeeping, clerical and communication, thrift shop, and food service. Recently, the prevocational program increased in size and variety, and payment to members for work in the food service and housekeeping unit was eliminated.

Attendance at Center Club is completely voluntary and there is an active membership of approximately 210 people who attend the club at least once a month. The council of officers is elected by club members. Council meetings are held weekly and are open to all club members. Staff are available to aid in coordination of all aspects of the program, to encourage participation, to develop and encourage relationships with and among members, to aid in the social growth of members, and to help in handling any crises. In the prevocational program, staff are available to coordinate and supervise, and to provide counseling and referral services.

For further information write Suzan Wolpow, 46 Carlton Street, #5, Brookline, MA 02146, (617) 277-1529. Ms. Wolpow is a former staff member at Center House, Inc. and served as the independent evaluator on the project.

EVALUATORS OR MONITORS

The primary evaluator was a former staff member from Center Club who was receiving training in program evaluation at the time of the survey. Dr. LeRoy Spaniol, director of research at Boston University's Center for Rehabilitation Research and Training in Mental Health, provided assistance throughout the project. Center staff and club members generated most of the content in the survey instrument. In addition, staff and club members monitored the administration of the survey.

REASONS FOR THE EVALUATION OR MONITORING

The Center Club needed some form of evaluation and data collection in order to provide program information and to involve club members in policy and decisionmaking. It had been 6 years since the last large-scale, formalized evaluation activity. In the interim, sporadic unsystematic surveys were carried out to collect information about members' program preferences.

LEVEL OF PARTICIPATION

Evaluation questions were formulated through a series of meetings with staff and club members. The survey instrument was drafted by the outside evaluator and reviewed by club and staff members, resulting in several revisions. The final copy of the survey was typed up for distribution by a member of the clerical and communications work cluster. Club and staff members were also primarily responsible for the actual administration of the questionnaire. Many members were excited by the prospect of involvement as can be seen by the response. Over a period of 10 days, 99 out of 210 club members completed lengthy surveys, an extremely high number for such a short period.

TARGET OF EVALUATION OR MONITORING

The evaluation focused on the Center Club program as a whole, including socialization and prevocational activities.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Some of the major evaluation questions were as follows:

1. Does Center Club provide a place for members to socialize/interact and develop social networks and social skills?
2. Does Center Club provide training and an encouraging environment for developing work goals?
3. Do Center Club members find the club helpful in being able to remain out of the hospital?
4. In what ways and to what degree are members willing to get involved in the functioning of the club?
5. What services could Center Club offer that would be helpful?
6. What services do club members see the club presently offering?
7. Does the club help members to use a wider range of community services?
8. What is the perceived level of satisfaction that club members have with their Center Club membership? What are members dissatisfied with at the club?
9. To what degree do members find the prevocational program favorable?
10. What basic needs are preventing members from living satisfactorily in their community?
11. To what degree does Center Club help members to fulfill their basic needs for living satisfactorily in their community?
12. How much support from other mental health resources outside of Center Club are members getting?
13. What are members' perceptions of the changes at the Center Club, and in themselves since they've joined?
14. How do club members feel about the present location of Center Club versus a site within a hospital or in a mental health setting?

TECHNIQUES USED

The questionnaire was developed based upon evaluation questions arrived at through meetings with staff and club members. At the first meeting staff were asked to list the questions they wanted to ask members, what they saw as Center Club goals, and what results Center Club should achieve. The survey was then discussed informally with a variety of club members, and a rough draft was written with the help of Dr. Spaniol. The draft was reviewed in a meeting involving both club and staff members and several new items were generated. The final survey was produced by the evaluator, using all of the information received at Center Club and incorporating one or two items from an earlier Center Club survey.

The survey was distributed during a 10-day period in 1982. Both staff and club members distributed, monitored, and aided members in filling out the survey at the club. In addition, approximately 25 questionnaires were mailed to club members not presently attending the club who had previously been active, in order to get feedback from a wider range of participants. Slightly more than half of those mailed out were completed and returned. The final number of surveys analyzed was 99, or almost a 50-percent rate for completed returns.

FINDINGS OF EVALUATION OR MONITORING

Center Club members found the program quite valuable in helping them to remain out of the hospital, develop social networks and skills, and expand their use of available community resources. There was, however, more casual support for the success of the program in the vocational area (i.e., providing effective prevocational training). The popularity of the club's social program in contrast to the prevocational program is not surprising considering the long history and predominance of the social program. Another interesting finding was that almost one-third of the respondents indicated by their responses that they were unclear about how to take responsibility at the club. This is worthy of note since much of the emphasis in this type of program is on member responsibility.

The vast majority of members indicated satisfaction with their club membership. The only area of dissatisfaction frequently mentioned was the lack of pay for their work. As mentioned, the club's policy on paid work had recently been changed and still appeared to be a sore issue for a significant number of members. Further, there were mixed feelings about the additional emphasis on the vocational area. Some members felt quite angry about the changes while others found the new programs quite beneficial. Significantly,

one-half of the respondents indicated that they would not come to the club if it were located in a hospital or mental health center setting.

RECOMMENDATIONS

The recommendations were addressed to the staff and active membership of the club. Specifically, the report suggested that some ways be found to address concerns in the prevocational area, either by calling special meetings, or through regularly scheduled groups. Through such discussions, these concerns can be recognized as legitimate, possible alterations can be suggested, and implementation of needed changes can take place. The report also addressed the lack of clarity among some members regarding responsibility to the club, and suggested that outreach methods be developed to help these members to learn how to become involved, and how they might contribute.

The remaining suggestions involved specific programing recommendations. In the area of social/dating needs, more club dances, trips to other social settings, and use of specific social skill groups were indicated as services that would be considered helpful by many members. Recommendations for implementing a social skills group were suggested in the evaluator's report.

STEPS TO ENSURE IMPLEMENTATION

One of the goals in planning this evaluation was to try to include implementation steps as part of the overall process of the evaluation. This was done in two ways. First, the final item on the survey questionnaire asked respondents to indicate how they would like to see the information from the survey used. In this way, respondents themselves were involved in making suggestions about how the information gathered might contribute to program improvement. Secondly, during the planning phase the evaluator explained that a final report with recommendations would be written and that some process for reviewing would be available. As a result, a committee made up of six club members and one staff member has been meeting weekly to review and discuss the recommendations and decide how they can most reasonably be implemented. The evaluator's report has suggested that the committee's recommendations take the form of specific, concrete plans and that the persons responsible for carrying them out be designated.

EXTENT OF IMPLEMENTATION

At this writing, all members of the evaluation review committee have read through the entire report and have met a total of six times. Following each weekly meeting, the committee reports its progress at the Center Club council. The evaluation review committee plans to have its final suggestions for implementation completed by mid-September 1982. At that time, a formal presentation will be made to the annual general membership meeting held at Center Club.

SPECIAL BARRIERS OR SUPPORTS

The amount of time available to produce and follow through with the evaluation placed certain constraints upon the project. The actual survey period was reduced from 2 weeks to 10 days because of an administrative backlog. The survey instrument itself had a number of open ended questions which, though valuable, proved to be difficult for many respondents to answer. In addition, these questions were particularly difficult and time consuming to score because of the wide variety of responses. More multiple choice questions would have been preferable. On the positive side, both staff and club members gave generously of their time, especially in monitoring the administration of the survey and helping members who needed assistance (in reading, etc.). In addition, the staff was quite receptive to the overall process and club members responded with enthusiasm and a great deal of energy in filling out the survey. The fact that the outside evaluator was a former staff person probably contributed to the project's success. Staff and club members felt more comfortable and therefore less suspicious about the possibility of misuse of the information because they were assured that the evaluator was familiar with the program, its intent, and its members.

RESOURCES AND COSTS

The cost of this project was minimal because of the voluntary services of the outside evaluator who contributed approximately 50 hours of work. This suggests the value of seeking out students in program evaluation to aid in planning and carrying out particular evaluation projects. Another possible resource for such projects is assistance from professional evaluators who may be willing to contribute some of their time, as Dr. Spaniol did, to serve as volunteer consultants.

Additional costs of this evaluation included postage for the 25 surveys sent out by mail (including stamped return envelopes), and the cost of paper, mimeograph materials, and envelopes. Center Club staff provided their time to help in the organization and monitoring of the evaluation.

ADDITIONAL COMMENTS

No additional comments.

13. Consumers Solicited to Review Children's Services

Lois P. Burgner

Florida Consortium for Research and Evaluation

SUMMARY

A Citizen Review Group (CRG), composed of clients and agency consumers of a community mental health center (CMHC) participating in the Florida Consortium for Research and Evaluation, reviewed children's services. The CRG generated 24 recommendations for submission to the center's governing board. Recommendations were both practical and feasible, and were, after some delay, acted upon by center staff. Recommendations concerned quantity and quality of service as well as community relations. Although the unique circumstances of the center affected implementation of the recommendations, 62 percent of the CRG suggestions were enacted upon within 8 months and 72 percent within a year. The CRG demonstrated the benefits of citizen participation in the evaluation of CMHC services.

TYPE OF ORGANIZATION

Citizens from the service area who represented the interests of consumers and who had expertise in children's expertise, were recruited by the center to review evaluation materials generated by CMHC staff. The resulting group included 14 persons: 7 staff members from schools and other agencies serving children, 6 parents of child clients, and 1 client. The CRG was chaired by two governing board members of the participating CMHC. The objective of the CRG was to make recommendations regarding children's services at the center.

EVALUATORS OR MONITORS

CRG agency members included school social workers, a child development center teacher, staff from Big Sisters and Big Brothers, and representatives from the State human services center. Family members of clients and one teenaged client participated. All members contributed to the discussions and most showed little or no reticence to disclose their identities or experiences. The group varied in age, economic status, and occupation.

For further information write Charles Windle, Ph.D., Service System and Economics Research Branch, National Institute of Mental Health, Room 18-C-07, 5600 Fishers Lane, Rockville, MD 20857, (301) 443-4233.

REASONS FOR THE EVALUATION OR MONITORING

The CMHC, as part of a research project to study different ways for the community to participate in center evaluations (as then required by the Federal CMHC Act), agreed to participate in citizen review. The governing board, after reviewing the center's annual evaluation report, requested that a CRG address the evaluation reports of children's services. The consumer perspective was considered an important balance to the views of CMHC administrators regarding planning for children's services.

LEVEL OF PARTICIPATION

The consumer CRG was an ad hoc advisory body convened by the center to review and react to program materials and to concentrate on client concerns. Recommendations were generated and written by consumers. Center evaluation staff and governing board chairpersons acted as facilitators of discussions and as information resources. CRG members also added opinions to the recommendations and acted as key informants for the impact assessment conducted 8 months after the recommendations were submitted.

TARGET OF EVALUATION OR MONITORING

CRG members concentrated on children's services at the center which included: child and adolescent outpatient services, inpatient services, an educational center for day treatment, consultation and education services, and a program for pregnant adolescents. The center, located in central Florida, serves an urban/rural population of about 250,000. The primary catchment area is a declining urban area, and 72 percent of center clients report annual incomes of less than $5,200. Fees are based on ability to pay and no person is denied services. Consequently, 73 percent of the center's funding comes from public revenues.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The center was concerned with soliciting consumer perspectives regarding the quality and appropriateness of center services for children.

Consumer perceptions of what was needed for children in the area would then be compared to State priorities for such services.

TECHNIQUES USED

Descriptions of the center and its services and children's programs, maps, and evaluation reports were provided to CRG members in an orientation packet mailed out before meetings began. CRG members participated in four weekly meetings and one followup meeting after 6 months. A list of State priorities for children's services was provided at the first meeting. Program overviews were presented by program directors and evaluation staff. Presentations by county recreation and transportation personnel and the Volunteer Action Agency director were requested by CRG members as pertinent to concerns arising from the discussions. The exchanges among clients, consumers of the agency's services, center staff, and governing board members produced a multifaceted list of concerns and recommendations.

FINDINGS OF EVALUATION OR MONITORING

CRG members were generally very pleased with the quality of the center's children's programs. Clients and family members praised staff and services, and reiterated the benefits of their own experience with center programs. CRG concerns centered on inadequate public funding of programs for children and youth, particularly preventive services for adolescents. Consumers pointed out a greater need for collaborative efforts in behalf of residential drug treatment programs for adolescents, recreational opportunities, training for city recreation personnel, and transportation programs for youth. Further, the CRG was concerned that the community was often unaware of many of the programs of the center. The consultation and education department was seen as an important link to the community for training and public education about the center, mental health education, and outreach.

RECOMMENDATIONS

Recommendations presented to the governing board were primarily concerned with community relationships (79 percent) and the expansion of services to youth and parents (17 percent). The CRG offered practical and specific suggestions. For instance, CRG members drew from personal and professional experience to suggest names of persons to contact for possible publicity and contributions of space. Key locations for staff training and expanded services were listed. The CRG also pointed out the reluctance of residents to come to the mental health center for child-care and parent-effectiveness classes, and suggested alternative sites, such as housing developments and churches. They encouraged collaboration between private and public organizations to promote recreational alternatives for adolescents. The prevailing limits of public funding were taken into account when the recommendations were written for submission to the center's governing board. Only four of the 24 recommendations (17 percent) required additional money to implement; most could be implemented using only one to two staff members (79 percent); and a minimum of effort (63 percent).

STEPS TO ENSURE IMPLEMENTATION

The reason for making two governing board members the chairpersons of the CRG was to insure that CRG recommendations would have advocates before the board. Theoretically, if the board members were committed to the CRG process, they could be expected to be enthusiastic about the recommendations, and to use their influence to enhance acceptance and implementation of CRG suggestions. The letter of recommendations was presented to the governing board exclusively, with further dissemination subject to their review and approval. Delegation of responsibility to carry out the recommendations was to be through the executive director of the CMHC to program staff. As it turned out, neither the chairpersons nor the center director lived up to these expectations and it was the intervention of a key person on the center staff that ensured implementation.

A 6-month followup meeting provided CRG members with a report on the progress of their recommendations. After putting time and energy into evaluation review, citizens were entitled to know what actions resulted from their efforts. The 6-month meeting also served to reaffirm the center's commitment to respond to the recommendations. While these purposes were not optimally achieved in this particular CRG, there is ample evidence from the consortium experience that followup is a crucial component in assuring good implementation of recommendations.

EXTENT OF IMPLEMENTATION

Of the 24 recommendations, 17 were implemented fully or partially within 8 months. Four recommendations for outreach services were accepted but were not acted upon because of limited staff and time. Recommendations that were inappropriate for the center to effect were translated into more feasible actions. The implementation report to the CRG, described above, was well received. Interviews with participants revealed that the CRG members were pleased with the center's reception and the actions taken. The experience was seen as a

positive collaboration and an effective means to promote communication between the center and its constituents.

SPECIAL BARRIERS OR SUPPORTS

The use of the CRG proved to be a viable mechanism for soliciting the community perspective and, in this case, the consumer perspective of center services. The structured, time-limited CRG meetings provided a relaxed, cooperative environment in which consumers, board members, and agency staff exchanged information, needs, and ideas for action. Involvement of governing board members in the CRG meetings lent credibility to the meetings and made the CRG members feel that their voices would be heard. On the positive side, former clients were eager to take part in the discussion and offered several suggestions which later became recommendations. However, a decline in attendance among former clients at later meetings proved to be a disappointment. Specifically, the final meeting and the 6-month followup meeting were attended exclusively by agency personnel. The contributions of former clients during the first three meetings, however, was preserved and included in the letter of recommendations.

The implementation of CRG recommendations was facilitated by the hiring of a key staff member within the 6-month followup period. The staff member, a public relations specialist, seized upon the recommendations and enthusiastically encouraged implementation. The staff member's dedication to the goals of consumer participation preserved the integrity of the process. This commitment was even more important since the expected advocacy of the recommendations by governing board members did not occur, nor did the executive director of the center assume responsibility for seeing that the recommendations were carried out. The letter of recommendations was in limbo at the center until the public relations specialist initiated actions for implementation.

RESOURCES AND COSTS

Approximately 160 hours of staff time were spread out over 8 to 12 months. A staff member with either a BA or MA was required for assembling the evaluation materials, organizing the group, providing resource support, attending meetings, and so forth.

ADDITIONAL COMMENTS

The topics discussed by this CRG served to promote a spirited exchange of ideas by citizens concerned with their children's welfare. More mundane topics, although timely and perhaps crucial to center personnel, may require recruitment of community members with more specific expertise. The use of consumers, and in particular former clients, provided the center with information that could not be obtained anywhere else. The clients' perceptions and feelings about services and personnel provided important considerations for service planning. Although the former clients in this study appeared to enjoy the exchange of ideas with agency personnel, they might have felt more support from an all-client group and this, in turn, might have encouraged their attendance and participation.

In groups where anonymity is not an issue, ongoing publicity about the CRG's efforts and distribution of its recommendations to center programs, oversight organizaions, and the media can promote the public relations value of the process and the goals of the CRG. Implementation of the group's recommendations can be facilitated by those with the capability to take action or to encourage the center to act. The fruits of the CRG experience cannot ripen in the dark.

14. Statewide Comprehensive Mental Health Surveys

Barbara Geddie

Mental Health Association of North Carolina

SUMMARY

Monitoring and assessment of mental health services in both the community and institutions is a major role of the Mental Health Association of North Carolina as part of its function as a citizen advocacy organization. In keeping with this mission, the professional advisory committee of the mental health association (MHA) worked with the North Carolina Division of Mental Health, Mental Retardation, and Substance Abuse to develop a plan for MHA participation in comprehensive surveys of each community mental health program in North Carolina. In 1978, an MHA member participated in surveys in each of the

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State's four mental health regions. This initial conclusion led to the agreement that an MHA member would be a full participant on each survey team and would be responsible for looking at community involvement and the responsiveness of mental health centers to community needs. This is in contrast to team members from the North Carolina Division of Mental Health whose focus is on meeting standards, record keeping, and the administrative and organizational dimensions of the program. MHA members complete a checklist which organizes information from community referral sources and from the onsite visits. Areas out of compliance and recommendations are included in MHA's official report which is attached to the division review. Local MHA chapters appoint or elect a survey team member.

TYPE OF ORGANIZATION

The Mental Health Organization of North Carolina is a volunteer service organization composed of 30 chapters throughout the State. MHA brings the perspectives of the client, the community, and the family to the survey process. The board of directors of the MHA is elected by local chapters. The purposes of the association are to work for: improved care and treatment for mentally ill and emotionally handicapped persons; improved methods and services through research; prevention, detection, diagnosis and treatment of mental illness; and the promotion of mental health.

EVALUATORS OR MONITORS

A survey guide developed and coordinated by the professional advisory board of the North Carolina MHA sets out requirements for MHA team members. Evaluators can be lay community members or professional members who are either retired or in private practice, but no survey team member can be an area board member because of conflict of interest. The MHA member on an area survey is an observer-participant in the area survey process. The MHA member is always part of a two-person subteam and is not the leader of that subteam. The basic role of the MHA member is to assess community involvement in, and community attitudes toward, the area mental health program, specifically the use and role of volunteers, attitudes of other agencies (particularly those that refer patients to the center), citizen awareness of the program, and mental health center responsiveness to community needs. Each MHA member is expected to comply with survey reporting requirements, and to makes a report to the North Carolina MHA.

REASONS FOR THE EVALUATION OR MONITORING

Although the North Carolina Division of Mental Health is responsible for reviewing mental health centers and agencies that receive Federal and State monies, the MHA believes that the citizen's perspective should also be represented. Such citizen advocates are necessary in order to identify areas of need that might not come to light during area surveys conducted by professionals only. The MHA also believes that such advocacy might expedite the expansion of needed programs for which center staff might be hesitant to push. Also, the MHA member is concerned with determining, during a time of budget decreases, whether cuts are made according to the endogenous needs of the community or the popularity of a program with the staff.

LEVEL OF PARTICIPATION

Association survey members are full partners in every stage of the project from the planning session through the reporting session. They gather data from the community prior to the actual review and use such data as a foundation upon which to inquire about the provision of services. The association team member is not allowed to review the actual patient charts and see confidential data but can be involved in discussions of patient issues.

TARGET OF EVALUATION OR MONITORING

The surveys focus on the provision of service by community mental health centers. Currently, the State regional hospitals are not included in the surveys although this is a goal for the future. The surveys are designed to cover all program areas within the mental health centers and contact is also made by the association team member with contracting agencies, referral sources, generic community agencies, and community leaders.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

While the State Division of Mental Health focuses on objective and measurable data to document delivery of services, the MHA member evaluates responsiveness of the program to the needs of the community. Consequently the opinions and judgments of the volunteers are basically subjective although based on collected data. A key problem is recruiting citizens who have received service through the mental health centers. The State looks at contracts, records, and reports and talks with staff and affiliates. Because of the issue of confidentiality, the MHA member is contrained from securing client records to evaluate service effectiveness.

TECHNIQUES USED

Telephone and face-to-face interviews with referring agents and contracting agencies provide

information about accessibility, availability, and responsiveness of services. Community demographic data is obtained to identify target groups, needs, and transportation routes to the center. Interviews with samples of clients are used to determine satisfaction with center services. Emergency services are evaluated by contacting the hospital, the outpatient department, a sample of private physicians, local counseling agencies, clergy, the police department, and the magistrate's office.

FINDINGS OF EVALUATION OR MONITORING

Technically, most of the centers are in compliance in terms of documentation of service. Key issues that continue to be identified as problems include: (1) transportation to the center or from the center to regional hospitals; (2) program cuts and consolidation of services, which lead to difficulty in adequately meeting the needs of clients; (3) inadequate followup of patients discharged from the regional hospital to mental health centers or nursing homes; (4) need for improved public relations and community education regarding availability of services; (5) need for group homes and halfway houses; and (6) need for increased outreach to specific target groups. Further, the inadequacy of services for children, particularly inpatients, appears to be a problem statewide.

RECOMMENDATIONS

Based on the surveys, The North Carolina MHA Board is in the process of reviewing problem areas and making recommendations to the division of mental health as well as forwarding the information to local MHA chapters. Since this is the first year that the surveys have been conducted in a structured fashion, there is also a need for revision of forms and increased coordination between the volunteers and the State division. Primarily, recommendations include: greater community education; increased services for children; improved coordination among regional hospitals, community centers, and nursing homes when patients are transferred from one facility to another; creative alternatives to meet the needs of the geriatric population confined to nursing homes and who are unable to get to the mental health center for service; improved followup; improved residential care in the community; and continued efforts toward smoother coordination among police and sheriff's departments, mental health centers, and regional hospitals.

STEPS TO ENSURE IMPLEMENTATION

The professional advisory board of the MHA will review all reports from volunteers and write a detailed report to present to the MHA annual meeting. The chairman of the professional advisory committee and the president of the North Carolina MHA will meet with the director of the division of mental health to discuss the findings and work toward improved coordination of volunteers and survey teams.

EXTENT OF IMPLEMENTATION

The division of mental health has been receptive to MHA surveyors' recommendations. Further, the MHA will lobby for legislative changes as well as monitor to see if the results of the surveys are followed through. Already some revision of emergency services is occurring across the State as a result of the participation of survey team members from the association.

SPECIAL BARRIERS OR SUPPORTS

The survey team members need to be supplied with copies of the previous onsite review as well as an opportunity to meet with the director of the center to review standards in areas of compliance. Because the volunteers are usually employed, it is necessary that they have adequate notice of the meetings and be provided with orientation materials in order to prepare for the review and to make community contacts prior to the visit. The MHA, through its advisory committee, is planning to provide greater in-depth orientation at the MHA annual meeting and has requested that the chapters identify their survey team members before that meeting in order for the team to receive appropriate orientation. Additional consumer involvement may be facilitated by contacting clients at local MHA social clubs, looking at notes in suggestion boxes, increasing media coverage, and publicizing a phone number to call.

RESOURCES AND COSTS

The volunteers supplied their own transportation and meals; the mental health center did not have any expenses; and the State and local associations did not have any budgetary allowances for the surveys.

ADDITIONAL COMMENTS

It is important to remember that this structured type of survey is in its first year of operation and that reviews in procedure and technique will be recommended.

15. Citizen Participation in Federal-State Site Visits

Diane Rich

Mental Health Association of Colorado

SUMMARY

The Mental Health Association of Colorado, in conjunction with the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services (DHHS) and the Division of Mental Health of the State of Colorado, participated in a joint site visit project evaluating the 23 centers and clinics in Colorado that were receiving federal funds. The joint project began in 1976 and stopped temporarily in 1981. The site visits resumed in 1982 without representatives from DHHS. This case report describes the earlier stage of the project in which Federal officials participated in the site visits.

TYPE OF ORGANIZATION

The Mental Health Association of Colorado (MHAC) is a voluntary nonprofit advocacy and education agency that works for improved care and treatment for the mentally ill, prevention of mental illness, and mental health education and research. It is an affiliate of the National Mental Health Association. The site visit committee of the MHAC consists of six to eight citizen volunteers, assisted by MHAC staff members. The citizens monitor the community mental health centers, clinics, and psychiatric hospitals throughout the State by participating in onsite evaluations. Committee members are appointed by the president of the board of directors of the MHAC.

EVALUATORS OR MONITORS

Over the years, members of the site visit committee have included mental health professionals, a patient representative in a general hospital, a retired accountant, housewives, students, and association staff. All members received training in methods of evaluation and were observers on two site visits before becoming evaluators. Some of the evaluators have been involved in the program since 1976. Each evaluator participates in a minimum of four visits per year. The citizen evaluators were accompanied by Federal and State officials on each site visit.

For further information write Diane Rich, Mental Health Association of Colorado, 1117 Cherokee Street, 3rd Floor, Denver, Colorado 80204, (303) 595–3500.

REASONS FOR THE EVALUATION OR MONITORING

The Mental Health Association of Colorado, as an affiliate of the National Mental Health Association, is concerned with improving the care and treatment of mentally ill persons and believes in the community mental health system. As the citizens' group representing consumers of services and those mentally ill persons who cannot speak for themselves, the association accepts the responsibility for assessing and evaluating community services funded by the Government. The Federal and State officers who also participated in the site visits were required by law to monitor the centers and clinics.

LEVEL OF PARTICIPATION

The site visit committee focused on twenty catchment area centers and three specialty clinics, a long-term treatment clinic, a children's clinic, and a clinic for Spanish-speaking (Hispanic) clients.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The site visitors monitored and evaluated multiple aspects of the center or clinic including: organization and administration, business management, facilities, quality assurance, emergency services, outpatient services, partial hospitalization, inpatient services, screening procedures, transitional halfway houses, followup, individualized treatment plans, range of treatment modalities, continuity of care, services for children and the elderly, community orientation, visibility, accessibility, preventive activities, consultation and education services, and coordination with other agencies. The MHAC site evaluation committee participated in all aspects of the site visits but focused especially on the community aspects, visibility, accessibility, consultation and education, coordination with other agencies, services to children and the elderly, and the role of the board. Federal and State officials concentrated on other areas of program operation.

TECHNIQUES USED

The evaluation groups participated in developing a site assessment instrument based on the

standards for the community mental health centers. The instrument is called the Review of the OnSite Evaluation Instrument (ROSEI). Centers were required to answer a preliminary questionnaire that was reviewed by the site assessors prior to the visit. A team of evaluators, composed mainly of Federal and State project officers, persons from other mental health centers, the Colorado Association of Community Mental Health Centers and Clinics, and the Mental Health Association then conducted the actual site visit. Onsite activities included interviews with staff, clients, and community agencies and viewing the various facilities and programs. In addition, the mental health professionals on the team also reviewed records.

FINDINGS OF EVALUATION OR MONITORING

The site assessors wrote a report that pointed out the programs' strengths and weaknesses (concerns) and made suggestions for improvements. The report also contained a Federal site assessment rating form that rated the required areas as follows: (1) excellent, (2) meeting requirements, and (3) not meeting requirements. It included a summary checklist of required services, procedures and policies. The final report was written by the Federal or State officers and included observations from all the visitors.

RECOMMENDATIONS

Some recommendations were made to improve services, but centers were not penalized if they were not immediately and completely implemented. Other recommendations were made to bring the centers into compliance with standards and ensure continued funding.

STEPS TO ENSURE IMPLEMENTATION

If a center was out of compliance, recommendations were made to bring it into compliance, and these steps were monitored by the Federal and State officials. If a center did not comply by a certain date, its Federal and State funding could be withheld. MHAC did not have any direct way of ensuring implementation on its own, but as part of the evaluation team its recommendations were included in the site reports.

EXTENT OF IMPLEMENTATION

In general, all centers were in compliance or met standards satisfactorily after the visit.

SPECIAL BARRIERS OR SUPPORTS

Initially, State and Federal project officers had to be convinced that MHAC participation on the site visits was appropriate. The MHAC volunteers soon proved their worth and in the last 2 years of the combined visits (after the State division of mental health dropped the comprehensive onsite visits) the Federal project officers relied heavily on the expertise and commitment of the MHAC volunteers.

RESOURCES AND COSTS

Site volunteers donated between 100 and 150 hours each year. MHA staff (clerical and professional) also spent many hours. Two or three staff members went on two to three visits per year. The average yearly budget over the program period was $1,000.

ADDITIONAL COMMENTS

MHAC site visitors feel that the program has been very worthwhile. It has developed their skills and has given them a knowledge of the mental health system. The reports that have been generated helped MHAC in planning other advocacy projects and in lobbying the State legislature. It was considered a very good experience by both the MHAC and the Federal officers.

16. County Board Assists in Assessing Local Services

Jean Fiore

Mental Health and Mental Retardation Advisory Board
Northampton County, Pennsylvania

SUMMARY

The Mental Health and Mental Retardation Advisory Board of Northampton County will be evaluating each of the eight services provided by the county mental health unit for the residents of the area. This case focuses on the first program evaluated, emergency services. The method chosen for the evaluation included interviews as well as a review of specific documents. Criteria were established that would assure the reviewers

For further information write Jean Fiore, R.N., Executive Director, Visiting Nurse Association of Bethlehem, 520 East Broad Street, Bethlehem, PA 18018, (215) 691-1100.

that the service was effective, adequate, and functioning efficiently. The final report included strengths, weaknesses, and recommendations for improvement of the service.

TYPE OF ORGANIZATION

The county board, made up of 13 persons, is advisory in nature unless otherwise specifically stated. Duties include review and evaluation of county mental health and mental retardation needs, service facilities and programs; assistance with the development of the annual plan; promotion of a better public understanding of the needs of the mentally disabled; and assistance in the development of policy. Members are nominated by the county executive and appointed by a majority vote of the Northampton County council. Nominees are community volunteers who have specific areas of expertise and are willing to commit their time. The term of the office is 3 years, and membership is rotating.

EVALUATORS OR MONITORS

This evaluation was conducted by a committee of six persons appointed from the advisory board. Committee members included social workers, clergy, nurses, a retired hospital administrator, and consumers. These areas of expertise were enhanced by other forms of community involvement such as school board membership, professorship at an area college, and administration of other health agencies. The committee received technical assistance from Dr. Jonathan A. Morell through the Northampton County department of human services.

REASONS FOR THE EVALUATION OR MONITORING

One of the duties of the advisory board is to review the programs and services included in the county's annual plan. It was felt that more in-depth evaluations of programs should be completed than had been done in the past. It was determined that three services should be evaluated each year. A model was established to provide the reviewers with uniform tools, and criteria were developed for each service. After a service is evaluated, the process can begin again using the same model. Therefore, a comparative analysis of evaluations over time will enable reviewers to document change and growth in each program based on recommendations from the previous evaluations.

LEVEL OF PARTICIPATION

The committee members were involved in all stages of the evaluation. Initial meetings were held to discuss and determine criteria. The method was developed including questions to be asked during the interviews. A session on role playing was held to give committee members necessary confidence in conducting interviews. After each member completed his or her evaluation tasks, meetings were held to compile data and to write the final report. County mental health and mental retardation staff were available as resource people in the development of criteria and to complete the necessary typing. Dr. Morell attended most sessions to provide technical assistance to the committee.

TARGET OF EVALUATION OR MONITORING

The first program the committee evaluated was emergency services, one of the eight services provided by the Northampton County mental health agency. This area was chosen because of its community visibility and its interaction with other community resources. Emergency services are available 24 hours a day for persons in need of immediate psychiatric care. Services range from telephone counseling to hospitalization for observation, treatment, and close supervision. The geographical area served is Northampton County, which includes both rural and urban areas. Emergency services staff receive calls from clients in distress, families, neighbors, police, physicians, and other human service agencies. Telephone calls during the day are received at the units in Bethlehem or Easton. In the evenings, calls are received by an answering service and referred to the on-call person at home.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The evaluation of emergency services in the county focused on service delivery, program administration, staff supervision, staff scheduling, inservice training, and orientation.

TECHNIQUES USED

The evaluation tasks included a review of the manual developed for emergency staff, review of administrative policy and statistical data, and interviews with the administrator, supervisors, and service staff. Each committee member assumed a specific area to assess. For example, the person who reviewed the manual was searching for criteria that the committee determined were necessary for a functional staff manual. Another member reviewed statistical data and interviewed the administrator. The remaining committee members interviewed the supervisors and the staff. Each level of interviews had specific questions based upon established criteria. The staff interviews were voluntary and confidential. The final phase of the project was to present the data according to the strengths and

weaknesses of the program, and to develop recommendations.

FINDINGS OF EVALUATION OR MONITORING

The committee members felt the entire process was beneficial not only because it resulted in a comprehensive evaluation and a model that can be used again, but the process was a good learning experience for the committee as well as staff.

The program strengths identified were: (1) a cohesiveness exists among the staff at all levels, and the supervisory backup plan is adequate; (2) the on-call workers had a positive attitude, and all felt that the service was important; (3) the answering service is very functional; (4) the tools used for gathering statistical data are excellent for completing an analysis: (5) the staff manual is helpful; and (6) the paperwork associated with being oncall is reasonable.

The areas of concern revolve around on-call duty at night, training and inservice education, and community resources. Nighttime on-call at the outset of the program was minimal; however, as the program grew, workers spent more hours handling calls, got less uninterrupted sleep, and burnout became a serious threat. Further, the worker on call at night must also work a regular day shift, but the assignment is voluntary. Many staff members volunteer in order to earn more money, while others volunteer because they get job satisfaction from working on this type of service.

The reasons for rejecting a nighttime on-call assignment were possible burnout, lack of confidence regarding nighttime on-call responsibilities, employee safety, and family responsibilities (primarily children). Safety and family are more likely to affect female employees. For example, husbands of female staff expressed concern for the safety of a spouse when she had to drive 50 or 60 miles during the middle of the night to a person in psychiatric crisis. Responsibilities for children prevented some employees from taking nighttime on-call duty because the spouse was working night shift, and the children were young and could not be left alone.

Transportation in emergency situations was also a problem. Each city, borough, and township has its own policies regarding whether ambulance squads and police will provide transport out of their jurisdiction. In addition, each hospital has its own admission system, and the on-call worker must be familiar with all admission procedures as well as with the hospital staff on admission units. There is an unwillingness among area hospitals to accept mental health patients for emergency admission during the night. Of the four area hospitals used, one in particular is extremely difficult to work with and does not accept its equitable share of patients. Meetings on the administrative level have failed to solve the problems of this hospital.

RECOMMENDATIONS

The committee suggested that staff orientation should be expanded to include outside workshops and seminars, as well as "how-to" sessions. Further, short-term counseling on specific cases was recommended, preferably the day after the situation arose. Monthly case conferences were suggested to ensure service continuity since some clients call the emergency services more than once. These suggestions will enable more staff to take nighttime on-call duty thus alleviating burnout and insecurity on the part of the staff. As an alternative, the committee also suggested that it may be advantageous to hire additional staff specifically for this program.

Hospital admission systems in all probability will not change. However, additional staff and improved training should enable staff to learn each hospital's system and develop a rapport with emergency room personnel. Transportation is an area that requires further work in order to find a solution to the problem. With respect to the hospital that does not admit sufficient clients, it is recommended that resolution be sought at the county administrative level.

It is recognized by the committee that recommendations and areas of concern cannot be addressed and changes made without additional funding for the program. Presently, the emergency program has a low priority in the budget, and the committee recommended that increased dollars be considered.

STEPS TO ENSURE IMPLEMENTATION

A detailed report of the evaluation was written and presented to the advisory board, chairperson of the county department of human services, the county executive and the state regional office. In addition, the committee met with county staff and discussed the report and recommendations. The report will also be included in the annual plan submitted to the state.

Reevaluations over several years, using the same model, will enable the committee to complete a comparative analysis and to assess the extent of implementation of the committee's recommendations.

EXTENT OF IMPLEMENTATION

Implementation of recommendations has begun in the budget for FY 1982-83, and further changes will be made as the dollars are available. Recommendations made at the county executive level are not completed to date, however, a report will be requested at the next regularly scheduled meeting of the advisory committee.

SPECIAL BARRIERS OR SUPPORTS

The preparation of the criteria, model and tools

to be used took many hours of work on the part of the committee. Members spent several hours in formal meetings with Dr. Morell, technical advisor, as well as in the review of data and preparation for the meetings. However, this beginning will enable the committee to structure the remainder of the evaluations more easily.

RESOURCES AND COSTS

Formal committee meetings and work sessions amounted to 306 voluntary man-hours. Based on a 7½-hour workday, this amounted to 40.8 workdays or 8.16 workweeks. This figure is conservative in that the time spent by each member in reviewing data and preparing for the sessions has not been calculated. The number of man-hours that the county staff, both professional and clerical, has spent on this project has not been maintained by the committee.

ADDITIONAL COMMENTS

The committee met with county staff to present and discuss the final report of the evaluation of emergency services. One of the other eight programs provided by the county is consultation and education services. This program provides inservice training on the organization of county services, including emergency services, to other community groups such as police, ambulance corps, and other service providers. The county staff have recommended that advisory board members participate in the inservice programs provided for the community.

17. A Consumer-Based Needs Assessment Examines Mental Health Services in One County

Ellen Colom Deacon and Thomas M. Quilter

Mental Health Association of Ohio

SUMMARY

The Mental Health Association of Ohio (MHAO), under a contract from the Office of Community Support Systems, Division of Mental Health, Ohio Department of Mental Health (ODMH), recruited a consumer group in Franklin County, (Columbus) Ohio, for the purpose of conducting a consumer-based needs assessment. Both MHAO and ODMH felt the need for greater consumer involvement in the design and planning of programs that ultimately affect persons served by Ohio's mental health delivery and volunteer advocacy systems.

TYPE OF ORGANIZATION

The Mental Health Association of Ohio is a nonprofit charitable voluntary citizens' advocacy organization, whose mission since its founding in the early 1940s has been to: (1) promote mental health, (2) prevent mental illness, and (3) improve treatment services for the mentally ill. MHAO, through its national affiliation and its 20 county-based chapters, works toward the achievement of this mission through wide-ranging programs in public information and education, legislative action, research, and volunteer service.

For further information write Thomas M. Quilter, Executive Director, The Mental Health Association of Ohio, 50 West Broad Street, Suite 2440, Columbus, Ohio 43215, (614) 221-5383.

EVALUATORS OR MONITORS

Two facilitators worked with the consumer group. They recruited members, conducted interviews, facilitated meetings, provided technical assistance, and compiled the final report. One facilitator was employed by the mental health association, the other by the Ohio Department of Mental Health. Neither were mental health clinicians. Another MHAO staff member observed the meetings to gain consumer suggestions for the design and development of a pilot MHAO advocacy program, Project PAVE (Patient Advocacy through Volunteer Effort).

The consumer group was composed of nine residents of Franklin County. Criteria for referral and inclusion in the group included:

- Ability to verbalize well
- Leadership skills
- Equal distribution of males, females and racial groups
- History of hospitalization or some involvement with daycare programs within the past year

Referral was made by aftercare coordinators from community mental health centers. Referral information included name, address, and telephone number. All additional information was provided directly by the individual. MHAO staff

conducted interviews with prospective members to define the program and to ascertain interest and willingness to serve. The group consisted of 5 men and 4 women, with an age range of 29 to 56 years. Their educational levels ranged from high school to graduate school. Two members were involved in daycare programs, three were college students, one a full-time secretary, one a professional pianist, one a manager of a card and gift shop, and one was seeking volunteer work. One member had never been hospitalized; some of the others had been hospitalized 10 or more times.

REASONS FOR THE EVALUATION OR MONITORING

Recognition of the need for a consumer group grew out of discussions between MHAO and the Office of Community Support systems, ODMH. Both organizations felt the need for greater consumer involvement in the design and planning of programs that ultimately affect persons served by Ohio's mental health and volunteer advocacy systems. Missing from prior needs assessments was direct information from service recipients concerning the adequacy and availability of services upon discharge. MHAO, particularly in reference to Project PAVE, needed consumer assistance in shaping program development and in defining advocacy objectives and activities.

LEVEL OF PARTICIPATION

The consumer group met nine times to identify needs, assign priorities, suggest an action plan based on identified needs, and plan future activities of the group.

TARGET OF EVALUATION OR MONITORING

This study focused on consumer-determined needs in Franklin County. Franklin County is served by four comprehensive community mental health centers, one State psychiatric hospital, general hospitals with inpatient psychiatric units, private practitioners, and several private psychiatric hospitals.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The consumer group addressed a broad range of issues relating to the delivery of mental health services in Franklin County. Some of the major foci were public education, confidentiality, staffing, discharge procedures, service gaps, medication, and the acceptability of certain types of treatment.

TECHNIQUES USED

Several methods were used to identify needs. The Nominal Group Technique (NGT) was used by the facilitators to assist with group problem-solving. The NGT encourages maximum participation of all members in identifying priorities. The "problem-centering" and "solution-finding" aspects of the project were stressed as tasks. The task, as identified for the consumer group, was to assess the county's needs and then to develop strategies to meet those needs.

Individual interviews were also conducted using a checklist form with 22 subject areas. The purpose of the interviews was to conduct additional needs, to assess in more detail the problems encountered at the time of discharge and reentry to the community, and to determine what coping techniques, strategies and problem-solving actions were required to resolve these needs. Although community needs were discussed with the group as a whole, it was felt that more specific information could be generated through individual interviews.

FINDINGS OF EVALUATION OR MONITORING

The NGT process proved to be a fruitful method for identifying the major unmet needs of the mental health consumers. Attendance at each meeting was remarkably good, communication levels were consistently high, and motivation to participate was maintained.

Lists of needs, ranked by priority, were generated by the consumer group. In terms of importance, consumers placed top priority on the urgent need for public education about mental health so that the stigma of mental illness could be reduced. The consumer group felt strongly that public attitudes regarding mental illness must be changed. Indeed, they placed this need ahead of more basic and individual needs such as jobs or housing. Improving the quality of professionals in the hospital was also seen as a pressing need, as were improvements in the quality of the hospital environment and treatment approaches. Specific issues included over-medication, therapeutic vs. punitive approaches, lack of individualized treatment, high-carbohydrate food, and the need for privacy such as showers in each hospital room. In total, the identified hospital needs concerned changes in the institutional ethos of State psychiatric facilities.

On the community side, consumers indicate that in addition to public education to reduce stigma, they also need help getting jobs, supportive friendship at critical times, and continuity of care. Other critical needs (in descending order of priority) included: help in getting along in the social world; temporary jobs before assuming full-time positions; legal safeguards on privacy; recognition as a person with worth and dignity; and greater responsiveness from the Social Security Administration.

It is important to note that the consumers in this group were selected to represent the

concerns of consumers in Franklin County only. However, it may be that their concerns may be generalized to a larger population of consumers. More groups such as this one are needed so that comparative analyses are possible.

RECOMMENDATIONS

The consumer group developed a number of recommendations to deal with needs identified within the county. The recommendations included: working with the news media to improve the image of former patients; development of employment-related programs; a self-help hotline; a buddy-system telephone network; improved procedures for confidentiality; increased dialog between consumers and hospital administrators; and placing consumers on hospital advisory boards.

STEPS TO ENSURE IMPLEMENTATION

Project staff members wrote a detailed report, subsequently approved by the consumer group, that included descriptions of the needs assessment process, techniques, results, and recommendations. This report was submitted by MHAO to the Division of Mental Health, Office for Community Support, Systems Planning and Development.

EXTENT OF IMPLEMENTATION

MHAO implemented the project recommendations in the following ways:

- Findings and recommendations were used in the design and implementation of Project PAVE, now underway in Franklin County.
- Findings and recommendations have been used to help formulate the MHAO's overall legislative program and advocacy thrust.
- Findings and recommendations have been used extensively in the MHAO's internal and external training program as well as in public education programs.
- MHAO has responded to nationwide requests for copies of the project results. Hopefully, this will stimulate the development of similar needs assessment processes in other areas.

SPECIAL BARRIERS OR SUPPORTS

Although the initial purpose of the consumer group was task oriented, the focus of the group appeared at times to be highly therapeutic. It is not paradoxical to find a work-oriented group producing such benefits; but it is questionable as to how much staff support and involvement with group members is desirable before the group begins to reflect staff opinions.

By the end of the formal consumer group meetings, the project task has been superseded by a strong group alliance providing peer support. Although future plans included the development of a constitution and bylaws for the group to continue as a consumer coalition, the group failed to remain cohesive after the formal activities ended. This failure can be attributed in part to the group's distrust of organizational help, including that from MHAO.

RESOURCES AND COSTS

MHAO expended $9,000 in direct costs to conduct the consumer needs assessment. The bulk of this was for project staff over the 6-month period. Other direct costs included supplies and transportation for consumers. Indirect costs for other MHAO professional staff time and other items were not calculated. In addition, indirect costs for professional staff time from ODMH were not calculated.

ADDITIONAL COMMENTS

MHAO is impressed with the initial findings of the needs assessment project. These findings reinforce the concepts developed by citizen advocates through the mental health association. The concerns expressed by the consumers regarding the hospital environment and the adequacy and availability of community-based services have been a primary concern of the association. The importance of the work done by consumers is evident and demands the attention of all people concerned with improving the mental health system and the attitudes in our society that serve to perpetuate the negative aspects of that system.

Additionally, the project identified the issues of community attitudes and stigma that have been a program priority of MHAO for considerable time. In light of these findings, MHAO believes that much can be accomplished through the continued cooperation of consumers.

MHAO strongly recommends that individual consumers willing to serve at both the chapter and State levels should be considered for appointments on mental health association boards and committees. MHAO will continue to utilize consumer reactions as a necessary component in both the development of Project PAVE and in other statewide programing.

The MHAO supports:

- Involvement of consumers at all levels of the association and provides for this by appointing consumers to the board of trustees and to committees.
- The formation of consumer groups both for self-help and for organizing to work for system changes.

18. Community Group Analyzes Mental Health Center Services

Rita T. Parle

Mid-Nebraska Community Mental Health Center

SUMMARY

A group of community leaders sponsored by the Chamber of Commerce, county medical society and board of trustees of the community mental health center established a study committee to research the functioning of the center. A 6-month study produced a report with 14 recommendations for the center board, 14 for the executive director of the center, and 6 for the county board of supervisors. The board was advised to limit its activities to policymaking, establishing annual audit procedures, and developing long-range planning procedures. The center director was advised to tighten internal management controls, and the county supervisors were advised to develop policies to eliminate conflicts of interest.

TYPE OF ORGANIZATION

The Mid-Nebraska Mental Health Center (MNCMHC) is operated by a volunteer board of trustees representing the 12 counties in the region served. Trustees are selected by their county boards of supervisors or commissioners for 3-year terms. The trustees elect their own officers. All major staffing and policy decisions are reviewed and acted upon by the trustees. Any citizen interested in the center and its operations is encouraged to contact the trustee from his or her county. An advisory committee assists the trustees in matters of programming and planning to meet the needs of the central Nebraska region.

EVALUATORS OR MONITORS

In order to explore issues that had grown up around the operations of the center, the board of trustees appointed a study committee. The chairman of the committee was a local banker. Other appointees included: an attorney, the vice president and general manager of a local radio station, a local physician, a retired colonel, the director of the local Chamber of Commerce, an elementary school principal, a current member of the board of trustees of the center, a certified public accountant, a local business executive, the assistant principal of a senior high school, and the newly hired executive director of the center.

For further information write Rita T. Parle, Executive Director, Mid-Nebraska Community Mental Health Center, P.O. Box 1763, Grand Island, NB 68802, (308) 381-5250.

REASONS FOR THE EVALUATION OR MONITORING

On April 21, 1980, at their regular meeting, the center board of trustees responded affirmatively to the suggestion of the chairman to appoint a study committee to investigate controversies that had surrounded operations of the center for several years. This action followed months of considerable debate regarding budgets and personnel at the center. These discussions occurred in many settings such as meetings of the center board of trustees, meetings of county boards and other civic groups throughout the community.

LEVEL OF PARTICIPATION

The members of the study committee conducted an intensive independent study, meeting every week for about 4 hours in full session, and privately in subcommittees. Center staff assisted in providing research and duplication of relevant materials. The Chamber of Commerce provided secretarial assistance. It was understood that there were to be no restrictions that would limit the inquiry of the committee.

TARGET OF EVALUATION OR MONITORING

The subject of the assessment is a comprehensive community mental health center located in Grand Island, Nebraska. The center provides services to 12 counties covering 8,200 square miles and a population of 112,000. Three satellite offices assist the main center in outreach to the rural areas.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The objectives of the study were as follows:

- To review all relevant documents governing the formation and establishment of the center and its board of trustees, including items such as any current arrangements, composition of the board of trustees and characteristics of the counties involved, procedural rules of the board, and Federal and State laws and regulations
- To review the mission of MNCMHC including the twelve primary services provided

- To review center planning activities, including the 5-year plan
- To review the organization and staffing of the center
- To review budget and finances
- To review the level of services to clients, including the magnitude of current and future caseloads
- To review the complaints and criticisms of staff, professionals, the general public, clients, and others
- To review physical facilities available to MNHMHC

TECHNIQUES USED

The above tasks were assigned to subcommittee teams made up of study committee members. With the assistance of center staff, a great many documents which bear upon the scope of the study were prepared, duplicated, and distributed to each of the study committee members. Each subcommittee was directed to review the documents provided in addition to attending all of the meetings of the committee and hearing all of the testimony to be offered. In order to solicit testimony from the public, the committee prepared and mailed a release to media within the 12-county area. The release was used by the *Grand Island Daily Independent* and local radio stations. Testimony was confidential and those wishing to appear were given appointments. The process required a substantial number of meetings. Twenty-three people appeared to testify in person and one individual gave testimony by tape recording. Several letters were also received by the committee which constituted comment or testimony. The statements received were from a wide variety of individuals, including professionals in the community who have reason to use the services of MNCMHC, lay members of the public who have used center services, current center staff members, and former center staff members. In addition, testimony was received from representatives of Government, and a former member of the board of trustees.

FINDINGS OF EVALUATION OR MONITORING

The findings of the study committee can be summarized as follows:

- The staff is extremely dedicated and concerned about delivering quality community-based mental health care to the residents of the 12-county area. However, at times, this dedication was overshadowed by the fact that persons were being asked to perform tasks for which they did not have the educational background. In other words, the overall staff quality, in terms of educational proficiency, did not keep pace over the years. In fact, the management quality of MNCMHC during the past administration deteriorated, and the quality of the staff deteriorated along with it.
- The board of trustees is generally dominated by one or two members appointed by the local county board of supervisors. This dominance coupled with the long-standing conflict between the local board and the center has served to create an unfavorable political atmosphere that reduces the ability of the staff to deliver high-level care to the patients of the center. In fact, the political nature of the board of trustees and its influ ıce on the center have caused job insecurity for current and former staff.
- There was a substantial number of conflicts of interests among staff, trustees, and other board members stemming from relationships with a variety of human services programs related to the center.
- On the positive side, the board of trustees appointed in April a new executive director for the center. Staff morale seems to have improved to some extent. In addition, certain other staff requirements were filled including the hiring of competent and well-trained therapists.
- The coordination of alcohol treatment services in the 12-county area is a problem. However, the efforts of the board of trustees to define the level of alcohol services to be performed by the center and also to encourage cooperation between center staff and other regional alcohol programs should be commended.
- A number of other positive steps were being taken to improve the physical facilities of the center and to improve public relations in the community, and with other medical and professional health care providers.

All things considered, the study committee resolved that services provided by MNCMHC are vital to the community and should be continued in the future. They saw the center's potential for becoming a model institution serving the public.

RECOMMENDATIONS

The study committee presented the board of trustees with 14 recommendations for themselves, 14 for the new director, and 6 for the county board of supervisors. In summary, the board of

trustees was advised to delegate to the new director full authority and responsibility for management and participation in policymaking. The board was also advised to establish an annual operational audit and cost study, a long-range planning process, and to seek more cooperation and consolidation with other human service agencies. The new director was to develop a strong organizational structure with internal controls, and to tighten and strengthen casework evaluation and supervision. Finally, the county board was to prevent actual or implied nepotism and conficts of interest, and to resolve the long-standing problem of leasing the center.

STEPS TO ENSURE IMPLEMENTATION

The report was printed, presented at a public meeting of the board of trustees, and released to the local media. Members of the study committee attended subsequent board meetings to be sure their report was addressed. The Chamber of Commerce continues to monitor the progress of the center through one member who became a member of the board of trustees. Several other members of the study committee have been appointed to the center's advisory board and thus continue to be apprised of progress.

EXTENT OF IMPLEMENTATION

Although several recommendations will take years to implement, the study committee agrees that most of the deficiencies have been corrected. In particular, the issues of conflict of interest and internal dissension have been remedied. The board of trustees and the executive director have a close and cooperative relationship which has assisted in the entire process. The hiring of new staff members has also had a major impact on quality and efficiency of services.

SPECIAL BARRIERS OR SUPPORTS

About a month after the study began, the city was struck by seven tornadoes which made Grand Island a disaster area. Although the board of trustees allowed another 6 weeks for the study, time constraints due to disaster work precluded a very thorough study. On the positive side, the evaluation was supported by intense interest from those working on it and by an unusually competent and responsible group of civic leaders.

RESOURCES AND COSTS

The Chamber of Commerce and medical society paid for any expenses other than duplication of center materials.

ADDITIONAL COMMENTS

If this study is done again, a year's time would be better than 3 or 4 months.

19. Citizens Monitor Services for Nursing Home Residents

Christine Anderson, Michele Bollenbeck, and Iris Freeman

Nursing Home Residents' Advocates, Citizen Advocacy Project
Minneapolis, MN

SUMMARY

The citizen advocacy concept was originally designed in the mid-1960s by Dr. Wolf Wolfensberger as a means of advocating for developmentally disabled citizens (Wolfensberger and Zauha 1973). Citizen advocacy is the pairing of a trained volunteer with a person in need of both companionship and protection. The model has been found very appropriate for meeting the individual needs of nursing home residents.

Citizen advocates serve in a variety of roles, both formal and informal. Formal roles include such activities as representation to obtain public benefits and protective or professional services. Informal roles include concern, friendship, guidance, and affection. Advocates may assist the nursing home resident in obtaining services; but, the essence of citizen advocacy is a one-to-one voluntary relationship. A citizen advocate may be the resident's only friend.

Of equal significance is the advocate's role as service monitor for the community because his or her repeated presence delivers the message that outsiders are mindful of residents' safety and rights. The advocate also brings an often-missing message back to the community, namely the daily experience of the frail older person living in poverty. The hope of the program is that expanded public awareness can grow into public accountability. The potential for change, then, rests not only in individual relationships and actions, but in the cumulative effect of advocacy involvement over time. Throughout some of the following sections, one case example is used to

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illustrate some of the characteristics of citizen advocacy.

TYPE OF ORGANIZATION

Nursing Home Residents' Advocates is a consumer service agency devoted solely to problems in long-term care. The organization provides services to current and potential nursing home residents and their families and friends through advocacy casework, community action, information, and support. The agency is staffed with specialists in social work, long-term care regulation, alternatives to institutional care, financial programs, research, community outreach, and residents' legal rights.

EVALUATORS OR MONITORS

Citizen advocates are all types of people. No professional criteria are used in screening. Volunteers are drawn from all segments of the community. The volunteers are interviewed to determine their commitment to the program's mission and to assess their basic communication skills. If accepted, their next step is an 8-hour preservice orientation in long-term care, residents' rights, and complaint resolution, the basics for a lay person's involvement in a complex and often confusing health care system. Inservice help with individual problems is available later.

REASONS FOR THE EVALUATION OR MONITORING

One case example explains why citizen advocacy is important. A referral of a nursing home resident was made by the organization's casework staff. The caseworker expressed concern that the person, who had recently been placed in a nursing home, had little or no regularly visting family. Coupled with lack of any short-term memory and progressive vision loss, her vulnerability would be very high in the best of circumstances. Given the public record of the facility where she was living, the need for immediate service and monitoring of care was apparent. The citizen advocacy coordinator's initial visit with this resident revealed cuts and bruises above her right eye and bruises and swelling around her upper lip. This finding, combined with the above-mentioned factors, made her a top priority for matching with a concerned and informed volunteer.

LEVEL OF PARTICIPATION

Each volunteer's monitoring/evaluation activities are tailored to the needs of the individual resident. The volunteers are provided with any information they feel is relevant (and which is either public information or released by the resident). They receive support and information from the program coordinator as well as others on the professional staff.

TARGET OF EVALUATION OR MONITORING

This type of monitoring/evaluation is done in nursing homes throughout the Twin Cities metropolitan area. The homes are chosen not so much for the risk factor or reputation but through preset criteria. The critical factor is that a vulnerable resident who requests service lives there.

In the case of the particular resident described above, the facility had a record of being deficient in compliance with several State licensure and Federal certification standards. Though at one time it had offered high-quality services, the facility began to deteriorate in 1977 when ownership changed. Since that time, its record has been consistently marginal.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The primary problem addressed by the citizens advocacy program is to ensure that nursing home residents receive an acceptable level of care based on their entitlements in law and regulation.

TECHNIQUES USED

During the first few months of the advocate's relationship with the resident described above, the resident was ambulatory, although she needed assistance. Even though she lacked short-term memory (she often confused the advocate with her daughter), the resident was able to converse with the advocate and at times appeared to remember who the advocate was. Some of the things which the resident and the advocate shared were:

- Sitting together talking
- Going for walks
- The company of the advocate's 2-year-old daughter
- Holding hands and touching
- Looking at magazines

During the next few months a series of events caused the resident's condition to become more serious. She suffered depression after the death of her only child. She became weaker physically. She seemed to lose some of her hearing. She fell out of bed. She developed fluid on her knee and was sent to the hospital for tests and observation. When she returned from the hospital, she seemed more withdrawn and did not speak to the advocate. Today, their activities are:

- The advocate talking to her
- The advocate taking her for rides in a wheelchair
- The advocate sending her flowers, cards, and candy

FINDINGS OF EVALUATION OR MONITORING

Despite her condition, the resident received no occupational therapy. It was questionable whether she had *any* therapy. After her hospitalization the resident moved to a more heavily supervised floor. None of her personal effects were visible. Either they had not been put into her new room or they were in the closet. The environment was new and impersonal, the very opposite of appropriate care for someone who is already disoriented. The resident did not have adequate personal clothing and did not seem aware that she had a small personal allowance to buy new clothing. Personal clothing appeared to be lost, or handled very carelessly.

RECOMMENDATIONS

One way to begin to protect this resident's rights to health services (therapy) and other rights (personal clothing, personal funds) is having the advocate represent the resident in negotiation with facility staff and public agencies.

STEPS TO ENSURE IMPLEMENTATION

Being developed.

EXTENT OF IMPLEMENTATION

As yet unknown.

SPECIAL BARRIERS OR SUPPORTS

The things that have made remedies in this case difficult are:

- The resident's physical and mental limitations
- Staff turnover which makes it practically impossible to establish any continuity in problemsolving

RESOURCES AND COSTS

Staff: 1 full-time project coordinator, $12,500 annually;
Volunteer hours: 40 hours;
Length of involvement in this case: 13 months.

ADDITIONAL COMMENTS

There are several things that the advocate feels she could have done differently:

- Spend more time with the resident
- Visit once a week
- Talk more to the social service agency
- Try to get in contact with her family (if any exists)
- Be a stronger advocate
- Not assume staff is uncooperative

The advocate feels that residents should be visited regularly (once a week) on the same day and time.

20. Council for Community Services Agency Evaluation

Beverly Kreis, Dave Heden, Steve King, Joan Merdinger, and Mary Kolsky

Council for Community Services, Providence, Rhode Island

SUMMARY

The Council for Community Services (CCS) evaluation task force evaluates community delinquency prevention and treatment programs funded by the Rhode Island Governor's Justice Commission (GJC). One example of such a program is the Sophia Little Independent Living Program, evaluated by a task force in 1982. Three task force members and the CCS evaluator served as a miniteam to assess the program's effectiveness as based upon client success rates and staff judgments about client outcomes. A review of client characteristics, program services delivered, and overall operation of the program was also conducted, together with a comparison study of other similar programs and their outcomes.

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TYPE OF ORGANIZATION

The Council for Community Services is an independent planning, evaluation and research agency, working under local, State and Federal contracts in the human services field. The CCS Evaluation task force was organized by CCS in March 1974, and is composed of approximately 20 human service professionals in such fields as mental health, family services, juvenile justice, law enforcement, education, and community organization/planning. The task force is chaired by a family court judge and there are also several lay representatives. The task force has a dual role: (1) to actively participate on miniteams that perform evaluation activities, and (2) to serve in an advisory capacity in overseeing the work of miniteams and in reviewing and approving evaluation reports.

EVALUATORS OR MONITORS

The evaluation of the independent living program was conducted by the CCS evaluator and three volunteer task force members. Two of these members work for the Rhode Island family court as intake counselors and one member works for the Providence school department as an administrator. The work of the miniteam was reviewed and approved by the full task force.

REASONS FOR THE EVALUATION OR MONITORING

This evaluation was requested by the Rhode Island Governor's Justice Commission, (GJC) as part of an ongoing contract with the CCS evaluation task force to evaluate four or five of the GJC-funded juvenile justice projects per year. The independent living program's funding was due to expire at the end of the year and an evaluation was seen by both the GJC and the program as desirable, whether for seeking new monies or making the decision to discontinue the program when GJC monies are terminated.

LEVEL OF PARTICIPATION

Task force members serving on evaluation miniteams participate actively in site visits to the various programs being evaluated. Specific activities in which they are directly engaged are record review, data gathering, staff and client interviews, and, to a lesser extent, provision of technical assistance to program staff. Depending upon the type of program being evaluated and the level of evaluation required, miniteam members also assist in pre-post studies, instrument design, and the interpretation of test results. The staff evaluator generally plays the major role in: formulating the evaluation design (with the aid of miniteam members); analyzing program data; writing site visit reports and the final evaluation report; formulating recommendations for program improvement and internal evaluation systems; and extending technical assistance both during and after the evaluation process to aid in the implementation of recommendations. Task force members serving on miniteams have continual opportunities for influencing these latter activities. Depending upon members' particular areas of expertise, their impacts can be both influential and significant. The full task force provides ongoing review and commentary for the miniteams and staff evaluator.

TARGET OF EVALUATION OR MONITORING

The Sophia Little Home for Girls in Cranston, Rhode Island, operates the independent living program for girls, ages 16-19, who have completed the residential (group home) phase of the program and are capable of living on their own and holding a job. The girls in the program have a history of family and emotional problems and were in foster care placements or State residential facilities prior to entering the residential component. The Sophia Little program has been operating for over 75 years, first as a home for unwed mothers and later as a 20-bed group home for girls referred by the State department for children and their families (DCF) or the juvenile justice system. The program is privately run and receives support from the United Way, private donations, and contracts with DCF and GJC. The GJC-funded independent living program was initiated in January 1980, as a statewide program to serve approximately eight girls per year.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The evaluation focused on the outcome of girls served in the independent living program. Four impact variables were selected by program staff and the CCS evaluation team as indicators of success. These variables were: (1) self-esteem, (2) decisionmaking skills/responsibility, (3) self-control/self-discipline, and (4) interpersonal and family relationships. Objective tests (before, during and after) and subjective assessment (e.g., client and staff interviews, and observation) were used to measure client success. Additionally, the miniteam reviewed program operations, management, and recordkeeping procedures relative to the quality of client services provided.

TECHNIQUES USED

The CCS evaluator and miniteam members made regular site visits to the program to develop the evaluation design, agree on appropriate evaluation instruments and procedures, review client records, assemble client profiles (characteristics) for each girl in the study, and conduct staff and client interviews. Evaluation activities

were conducted by program staff, the CCS evaluator, and the citizen evaluation miniteam. Each client was tested at three points over a 6-month time period and test results were analyzed by the CCS evaluator and miniteam. Program staff filled out behavior checklist forms on each client at the same three time intervals as the client tests, and their assessments were compared with client test results. A client interview form was developed by the CCS evaluator and miniteam members and interviews were conducted with each client at the conclusion of the evaluation period. Results of these interviews were compared with client tests and staff assessment results. Overall program effectiveness was analyzed on the basis of the above measures, and a final report was prepared by the CCS evaluator. Joint recommendations were formulated by the CCS evaluator and the miniteam members, and the complete evaluation report was reviewed and approved by the entire CCS evaluation task force. Suggestions from the CCS evaluation task force were included throughout the evaluation process and they had the opportunity to review staff and miniteam activities at regular monthly meetings throughout the 6-month evaluation period.

FINDINGS OF EVALUATION OR MONITORING

The evaluation of independent living program by the CCS evaluation task force suggested that the program was providing good services to a very difficult and challenging population. Clients in the evaluation study demonstrated progress in self-esteem, self-control, and decisionmaking skills and slight improvements in their interpersonal and family relationships. Several problems were identified. They included the need for closer supervision and a longer and more structured transition period between group home residency and independent living. More definitive criteria for client acceptance were also seen as necessary in order to better screen potential clients.

Overall, the program seemed to be operating well, but staff determined that in the absence of further GJC funding they would discontinue the independent living component in favor of establishing a stronger aftercare/transitional facility for girls leaving the residential group home component.

RECOMMENDATIONS

The CCS evaluation task force recommended: (1) a more structured screening process for clients, including specific acceptance criteria; (2) a transitional period of supervised living prior to placement in an apartment; (3) continuation of internal evaluation procedures using the instruments developed during the CCS evaluation; (4) refinements in recordkeeping to include specific short- and long-term client goals and monthly review of progress toward these goals; and (5) continuation of supervised independent living for as many as six girls per year if alternative funding were available. These recommendations were made to the program itself through the Governor's Justice Commission which had the authority to implement the recommendations.

STEPS TO ENSURE IMPLEMENTATION

The CCS evaluation task force offered technical assistance and feedback to program staff throughout the evaluation process so that, at its conclusion, recommendations regarding internal evaluation, recordkeeping, screening, and providing a transitional period were already implemented. The GJC, as the funding authority, reviewed the task force's recommendations and met with program staff to review compliance. They also offered assistance in attempts to locate additional funding for program continuation. Short-term GJC funds became available and the program opted to strengthen the transitional aftercare component with existing resources.

EXTENT OF IMPLEMENTATION

All recommendations of the CCS evaluation task force were implemented to the extent possible.

SPECIAL BARRIERS OR SUPPORTS

There were no particular barriers to the evaluation. Major supports were the cooperation of program staff, the active participation of citizen volunteers, and the strength of the evaluation techniques employed. Program staff were so pleased with the evaluation instruments and procedures utilized by the task force that they are now using them routinely to evaluate the effectiveness of their total program.

RESOURCES AND COSTS

Three citizen volunteers each donated approximately 20 hours of their time over the 6-month study period. Each task force member donated another 12-15 hours to the evaluation. The CCS evaluator put in approximately 100 hours for data analysis and report writing, as well as site visit supervision, at a cost of about $1,200. Clerical support amounted to another $300 and agency overhead and supplies added an additional $375, for a total evaluation cost of $1,870. The Governor's Justice Commission provided the funds for the evaluation.

ADDITIONAL COMMENTS

The task force's approach involves program staff in all stages of the evaluation and uses a formative/technical assistance style. As a result,

the evaluation of this program was a positive, interactive process for all involved. Recommended program changes were implemented quickly and without the need for coercion. The task force had the immediate sense that the program had benefited from the evaluation. This kind of experience makes the citizen volunteers feel that their time has been well spent.

Task force members, as a whole, felt that they had made a useful contribution in their roles as citizen volunteer evaluators. Most members saw their contributions as opportunities for offering substantive expertise in their professional fields. Additionally, they were aware that they brought an objective third-party perspective to the evaluation process. Members felt that they, too, had benefited from their experience on the task force. Major benefits they cited were a broader knowledge and awareness of social service programs in the State and an opportunity to learn and apply evaluation and research skills in a "real world" setting.

Scope or How Far Will You Cast the Net?

Having assessed their organizational context and the extent of their involvement, Doug Brown and his committee are now ready to examine the scope of breadth of their evaluation task. There are several factors that influence this choice. First, Doug reminds the committee that the motivation for the formation of the group in the first place was the association's concern about the lack of systematic county planning and the absence of realistic service and funding priorities. It is difficult to imagine how Doug's committee can satisfy this concern with an evaluation that focuses on only one program component.

Second, Doug cautions the committee that their choice of scope must also be dictated by the level of resources available to carry out any evaluation or monitoring activity. Though, like most citizen groups, Doug's committee is composed of volunteers with limited time, some of the members do have special expertise and access to other forms of assistance that will be valuable during an evaluation. For one thing, one of the committee members is an instructor in systems analysis at Calvin Coolidge Community College. His skills will be enormously useful in processing and analyzing any data collected, and he also has access to student assistance.

Another member of the board is a certified public accountant who is willing to assist in exploring cost and funding issues. Finally, Doug has secured the cooperation of the county mental health advisory board, which is willing to share information and to provide other in-kind support.

The decision regarding scope also is contingent upon the extent of influence that citizen evaluators can expect to have. In this instance, the Greene County Mental Health Association's success in securing expanded funding for local programs has ensured the cooperation of the county mental health department in the study and at least a sympathetic hearing of any recommendations.

The combination of all these factors persuades Doug and his committee that they have the organizational support, the resources, and the political climate necessary to carry out a countywide study of mental health programs.

The cases highlighted in this chapter fall into four categories of descending magnitude or scope: statewide system, county or regional system, agencywide, and individual program component. Another possible category under scope is "cluster." Although no cases illustrating cluster are presented in this section, other cases, such as the Greater Chicago Mental Health Association Site Visitation Committee, represent this component of scope. In these cases, evaluators or monitors frequently review multiple facilities or programs.

Statewide Systems

The first two cases, written by Lawrence Velasco and Bruce Braman, exemplify statewide system evaluation and monitoring. Velasco describes the Colorado adult residential services monitoring project sponsored by the State developmental disabilities division. This statewide project was initiated in 1978 because of the increasing size of the community residential system and the difficulties encountered by central office staff in monitoring multiple providers in such a large state. To carry out the monitoring, volunteers were recruited from three regions. Information collected by the monitors during site visits was fed back to the State and ultimately into the State licensing process. As a quality assurance process, the Colorado monitoring project proved very successful. As an ongoing quality assurance technique, however, it failed, since funding for the project was not continued. Though the scope of the project did not directly affect the citizens' ability to secure continued funding, it does suggest that a smaller scale effort would have been less costly and perhaps easier to implement.

The issue of funding is also a consideration in

Bruce Braman's description of the Nevada rural clinics evaluation. Since the evaluation is mandated by State law, however, the source of funding for the effort is more stable. The rural clinics program is State operated and provides a wide range of mental health services to 15 rural counties and the Carson City area. In most areas, no other private mental health services are available. State staff view the involvement of citizens as critical to continued public support for the clinics. Moreover, a grassroots effort that feeds into a statewide review of needs and service options is essential in a State like Nevada. The geographic distances and time involved in travel have limited significant citizen participation in some rural areas.

County or Regional System

The Sacramento County Mental Health Association focused its activities on the seven agencies under contract with the Sacramento County mental health division. In this case, written by Al Dekker, the countywide system was targeted because of a recent change in program administration. Alteration in the patterns of service utilization following the change in county program auspices stimulated the association's concern and subsequent evaluation. The association's focus on the county system was especially important given the change in administrative auspices. Even though the association's analysis and findings were critical to county operations, its recommendations were internal to the association and therefore of limited influence in the county.

Agencywide

Ralph Denty, from the Brunswick, Georgia, area, describes how the mental health association in that community carried out an agencywide evaluation in partnership with the local mental health advisory council. The target of the evaluation was the service delivery system of the Coastal Area Community Mental Health Center. Secondarily, this case also exemplifies an evaluation of a regional service system since the center's catchment area covered seven counties. The collaboration between the mental health association and the local advisory council allowed the evaluators to extend the target of the evaluation to include the entire catchment area. As a result of the comprehensiveness of the review activity, many problem areas were identified and resolved.

Joan Wooley and Dorothy Kurjan describe another agencywide evaluation, one that focuses on the delivery of emergency shelter services to children and adolescents in the western region of Massachusetts. In the spring of 1982, members of a children's committee, mandated by State law to review and assess children's services, conducted an evaluation of The Shelter, an emergency shelter for adolescents. The focus on one agency's service system permitted committee members to address in-depth specific concerns regarding the ongoing stability and quality of services being provided by the program contractor. As a result of their investigation and subsequent recommendations, the existing vendor was changed, and other administrative changes were made.

Program Component

In the final subsection of this chapter, two different cases exemplifying evaluation of a single program component are described. Elizabeth Fulton and Bruce Hirsch, in case #27, write about the San Francisco Mental Health Association's (MHA) preliminary evaluation of psychiatric emergency services provided in two San Francisco hospitals. Members of the MHA's public affairs committee selected psychiatric emergency services as their focus since they function as the hub of community mental health services in the San Francisco area. Eight MHA volunteers organized and implemented the evaluation with the assistance of the directors of the psychiatric emergency services units. By targeting their evaluation to a specific program component, association volunteers were able to obtain additional knowledge and experience in a critical service area, while gaining credibility in the eyes of the professional medical community for their interest in, and commitment to, improving emergency services. The initial results of this evaluation pointed to the need for another study to identify the availability and appropriateness of referrals for psychiatric emergency services.

In case #26, Jan Foutz and Barbara Goza highlight the Salt Lake City, Utah, Granite Community Mental Health Center Advisory Council's evaluation of the adult outpatient services group orientation procedure. In this case, both center staff and advisory council members recognized the need for a new orientation process but were concerned about potential implementation problems. The scope of this evaluation, therefore, focuses on one aspect of one service-delivery unit in one CMHC. After conducting an extensive research effort that included analyzing complaint files and client flow data, members of the advisory council were successful in implementing many of their recommendations. One of the key factors in their success was the early involvement of the unit staff and management in the evaluation process.

21. A Statewide System for Monitoring Community Residential Services

Lawrence A. Velasco

Pueblo County Board for Developmental Disabilities, Inc.

SUMMARY

The Pueblo County Board for Developmental Disabilities, Inc. participated in the development and implementation of a statewide *System for the Monitoring of Community Residential Services* beginning in the summer of 1978. This monitoring system is the product of the Colorado Division for Developmental Disabilities' residential section. The objective of this unique system is to provide an annual onsite monitoring and evaluation of all community-based adult residential facilities licensed by the State of Colorado and funded through the division for developmental disabilities.

TYPE OF ORGANIZATION

The system for monitoring of community residential services was organized by the residential system of the Colorado Division for Developmental Disabilities. Because of the large geographic size of the State (104,247 square miles) and because of the number of residential facilities being developed (68 community facilities) it was imperative to initiate an accountability system that would insure quality control of all physical facilities and client programs being planned or provided throughout the State. A team concept was utilized to formulate the nucleus of the system.

Each team was composed of persons representing one of the following areas: The State division for developmental disabilities, an association for retarded citizens, a community-centered board, the developmental disabilities council, and one of the three State home and training schools.

EVALUATORS OR MONITORS

The State was dissected into three regions. Each region has persons on a list of eligible evaluators who have volunteered to take part in this exercise. These individuals have professional, paraprofessional, or consumer representative backgrounds. All persons are trained in the process of the evaluation by a member of the residential section of the division for developmental disabilities. The training session covers the philosophy, rationale, evaluation checklist, and rating procedures to be used. The division residential section selected regional team leaders who are responsible for assigning the volunteers from their region for site visits. The schedule for evaluations is made in October and all evaluations are completed during the winter and spring.

REASONS FOR THE EVALUATION OR MONITORING

Colorado launched into the process of deinstitutionalization after the completion of a statewide study entitled *The Environmental Design Group Study* which was completed in July 1978. The study identified the inadequacies of the three State institutions and identified large numbers of individuals who could be better served in the community in small eight-bed facilities. Since the division for developmental disabilities had been contracting since 1965 with 22 community-centered boards in the State to provide day program services to developmentally disabled clients, it seemed highly appropriate to expand those community services and some existing group homes to include institutionalized individuals who could profit from a community residential environment. As the number of group homes began to increase in 1978, the division for developmental disabilities recognized the need for instituting a monitoring system that would inhibit the practice of "warehousing" in the community. Although the Colorado State Legislature and the executive branch of government were completely in favor of the deinstitutionalization process, monies had not been appropriated for the monitoring portion of these services. Therefore, the State developmental disabilities council funded a grant of approximately $4,200 to develop and implement a process of evaluation and monitoring of adult residential facilities throughout the state.

LEVEL OF PARTICIPATION

The Pueblo County Board for Developmental Disabilities, along with several other community-centered boards, was asked to assist with the development of a monitoring and evaluation tool by the State division staff. The Pueblo board had been included because it had successfully provided childrens' residential services since 1970. It had decentralized its large community facility of 42 beds to 6 bilevel homes spread

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throughout the community, thereby establishing itself as an authority in small group homes. All participating community center boards provided items for the checklist and suggestions throughout the process of evaluation.

TARGET OF EVALUATION OR MONITORING

The first site visits took place in the fall of 1978. The objective was to review 68 residential facilities by June 1979. The teams reviewed facilities in Boone, Alamosa, Salida, and Colorado Springs. One full day was allotted for travel to and from each site and for the administration of the evaluation. Travel time ranged from 30 minutes to 2 hours. The Boone Guest Home is located approximately 20 miles east of Pueblo in a small farming community of approximately 200 people. The facility is a "mom and pop" operation and is located in a renovated boarding home. This facility is one of the larger group homes and is licensed for 15 adults. Each adult has his/her own separate bedroom and all residents share a common recreation/living room and dining room. The Alamosa Group Home, which houses eight clients, is located about five blocks from the downtown area. Alamosa is a community of about 30,000 and is located in the San Luis Valley approximately 80 miles south of Pueblo. The Salida Group Home is located approximately 100 miles west of Pueblo and is in a community of about 10,000 people. The Colorado Springs facility is located in the mountains and is called Cheyenne Village. There are 4 cabins that house 10 persons each. Colorado Springs is located approximately 50 miles north of Pueblo and has a population of 300,000. The Pueblo County Board operates four adult group homes in the city and county of Pueblo. Pueblo has a population of 125,000 and is located approximately 110 miles southeast of Denver, Colorado.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The checklist for monitoring community residential services focuses on a number of areas: (1) physical setting (location in the community); (2) accessibility to the community (recreation, shopping); (3) interior design (normal environment, personal space, and group activity space); (4) private areas (design and furnishing of bedrooms); (5) resident programs and services (food, grooming, attention to learning, community living); and (6) administration (program management, general support services, management of residents' rights, dignity, safety, and resident movement to less restrictive living).

TECHNIQUES USED

A checklist with 71 items was used by each member of the team. Each person was responsible for completing his/her own ratings. Prior to the administration of the evaluation, the team leader introduced team members to the staff and any residents present. The team leader reviewed the survey process with everyone, including the purpose and procedure for the postvisit team conference. The team was divided into two groups. Group A interviewed direct care staff with particular attention to section 2 of the checklist. Group B interviewed administrative staff and attended to checklist section 3. The process takes approximately 4 to 5 hours because of the number of questions that need to be addressed.

FINDINGS OF EVALUATION OR MONITORING

Our agency staff have benefited greatly from this evaluation process because of the amount of sharing between team surveyors and staff persons answering questions about our programs. Our experience is that every group home has an individual personality and is unique with respect to the operators, decor, furniture arrangements, meal preparations, leisure time activities, community involvement, etc. One universal problem affecting the group homes is the training of facility staff. Because of the funding level, most programs have only a minimal orientation to residential services and developmental disabilities. It is apparent that the State must try to secure funding for additional courses in developmental disabilities, program development, normalization theory, client assessment, and provide a continuum of learning sequences. Generally speaking, however, the programs are effective and the residents appear to be happy. The process of monitoring and evaluation does appear to play a large part in enhancing agency pride. Everyone wants to be a part of a winning team.

RECOMMENDATIONS

After the onsite evaluation, the team reconvenes to complete the consolidated checklist answer sheet. The team reviews each item and secures a consensus on the rating. Recommendations are made by the team members in order to assist the group home operator in improving his/her services. Ideas are given and are recorded on the evaluation sheet. The division for developmental disabilities staff member takes this information back to the central office and sends out an official evaluation with ratings and recommendations.

STEPS TO ENSURE IMPLEMENTATION

At the end of the evaluation, an exit conference is held with the facility operator. The full checklist is reviewed and recommendations for

improvement are discussed. The facility operator is also praised for the positive aspects of the programs and facilities. Within 2 weeks, the operator receives the official evaluation and is given approximately 1 month to provide a plan of correction for the items that are in need of remedial action. In the plan of correction, the operator must identify the dates by which all deficiencies will be corrected. If any items are of great significance, division staff return to review the required changes. It has been our experience generally that everyone is willing to cooperate with the changes as required. One of the reasons for such cooperative attitudes is believed to be the peer review procedures. Because their ideas are sought in the evaluation process, the operators do not feel as though they are being attacked or pressured. Over the 4 years of evaluations, a measurable level of improvement has been seen in the system of adult residential services.

EXTENT OF IMPLEMENTATION

This system of monitoring and evaluating adult residential services in Colorado must be labeled a magnificent success. One hundred percent of all adult residential facilities licensed to serve developmentally disabled in Colorado are evaluated annually. All facilities are required to participate as part of the criteria for funding and licensing. This process has brought all operators under the umbrella agency of the division for developmental disabilities and has enhanced the collection of data in all categories of operation. This information, coupled with quality control, has provided the Colorado State Legislature and the executive branch of government with the verifiable assurances of the staff of the division for developmental disabilities and the State developmental disabilities council that adult community residential services are a viable service delivery system.

SPECIAL BARRIERS OR SUPPORTS

From the very beginning, there was a big response from the field to volunteer for the evaluation process. The only expense that the division incurred was the cost of travel and per diems. However, because Federal and State monies are becoming tighter, these funds may not be available in the future. The system, we hope, will continue to provide the volunteers to insure that the quality control continues even though it may cost each agency and individual a few dollars.

RESOURCES AND COSTS

During the first year of the evaluations, the division scheduled 150 volunteers and evaluated 68 group homes. In 1981, 150 volunteers evaluated 76 group homes. Currently there are 122 facilities in the State and this number is expected to increase to 150 facilities by September 1982. The division for developmental disabilities is trying to secure approximately $6,000 for the travel and per diem expenses of about 200 volunteers.

ADDITIONAL COMMENTS

Generally, all community center boards in Colorado have been supportive of this system of evaluation and monitoring. It has become an accepted part of our service delivery lives. The process is being replicated in another area of service delivery in our State system--transportation services. It is anticipated that this new venture will meet with equal success.

22. Citizen Groups Evaluate a Statewide Mental Health System in Nevada

The Reverend Bruce O. Braman

Advisory Council for Rural Clinics Community Mental Health Center

SUMMARY

Citizens play an active role in providing guidance and evaluation for the Rural Clinics Community Mental Health Center (RCCMHC). Local groups, be they mental health advisory boards or mental health associations, provide ongoing feedback to the local satellite clinics and their staff. An advisory council represents the collective views of citizens in the rural counties of Nevada and communicates these views to the central administrative staff. This case describes one of the periodic evaluations that utilizes two levels of citizen involvement. The local advisory boards conduct community forums that allow citizens to express their views on mental health issues and needs and on the quality of service provided by the satellite office. The boards also administer questionnaires designed by the central administrative office that generate specific and valuable data. The second level of citizen involvement is the advisory council. The system-wide advisory council participates with repre-

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sentatives from the satellite offices, their managers, and central administrative staff in an annual evaluation session. The previous year's objectives and operations are critically assessed. Data from satellite areas are reviewed and a set of recommendations is produced to serve as a basis for an action plan for the Rural Clinics CMHC during the coming year.

TYPE OF ORGANIZATION

The local advisory boards may take varying shapes. In some areas, the county mental health association agrees to provide the citizen advisory function. In other areas, the advisory board is linked directly to the Rural Clinics CMHC. In either case, the citizens themselves tend to generate membership from among their friends, professional contacts, and community leaders. In a few places, satellite office managers may have varying roles in constituting a board's membership.

EVALUATORS OR MONITORS

The evaluation is carried out at the local level by advisory board members in conjunction with the advisory board member representing that catchment area. The makeup of the local boards varies from place to place, but typically includes: professionals involved in providing human services, government officials, representatives from business, and citizens with an interest in mental health issues. Their varied interests and wide assortment of contacts provide a good mix for generating helpful data. Staff members in the Central Office of the Rural Clinics CMHC provide evaluation data and access to clients and former clients.

The annual evaluation session attempts to synthesize the information collected at the local level and turn it into manageable recommendations. At this point, care is taken to include three persons from each catchment area: the satellite office manager, one professional staff member (psychologists, social workers, etc.), and the advisory council member. The central staff is available for consultation and guidance. They also represent policies from state offices that have a bearing on the issues under study.

REASONS FOR THE EVALUATION OR MONITORING

The evaluation is mandated by State law, but this fact does not really tell the story. The central staff encourage and solicit the evaluation and have consistently regarded citizen involvement in the process as critically important. The evaluation is conducted annually and its results are reviewed by the State Division of Mental Hygiene and Mental Retardation. Program policies are established as the result of recommendations that emerge in the evaluation process. The evaluation also serves a more crucial function; it is an invaluable source of support to the rural clinics program when programs and budgets are presented to the State legislature.

LEVEL OF PARTICIPATION

This author has been able to experience the evaluation process from several vantage points. Typically, the identification of areas to be evaluated are designated by central staff. At some points, however, the advisory council has, on its own, carried the evaluation into other areas. At the local level, it has been interesting to collect data both formally (community forums, questionnaires) and informally (such as interviews with office managers and staff of the local center). At the area level, both the advisory council's evaluation of data and the large annual evaluation session have shown the agency's ability and willingness to respond to the evaluation recommendations both openly and creatively.

TARGET OF EVALUATION OR MONITORING

Rural Clinics Community Mental Health Center, an agency of the State of Nevada, has a mandate to provide a wide range of mental health services to the rural counties of the State. The area covers 15 counties and the Carson City area. Only the two highly populated counties, Washoe and Clark, are excluded from its service area. The agency covers an area of 96,000 square miles and a population of 154,000 or 1.6 persons per square mile. The communities served are typically small cities or towns. The author's own town has a population of 12,000 and the local mental health center serves a county the size of New Jersey. This is typical.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

In this evaluation, attention was given to all aspects of the current services of RCCMHC. In later stages of the evaluation, priorities were assessed and certain services were deemphasized in agency policies. Special attention was given to community needs that were not being met. The evaluation also covered the clinics' management information systems, the future roles of the center's advisory board and council, central office functioning, and the development of community support strategies.

TECHNIQUES USED

The following methods were used to gather and process information:

1. Preliminary sessions at the local level--these sessions focused on specific

issues and needs that were relevant to the local areas. They furnished hard data from the local level through questionnaires and the management information system.

2. Evaluation sessions at the advisory council level--members of the advisory council participated in one of six task forces, each of which addressed a different issue. (The issue differences included: the management information system, the role of boards and the council, strategies for developing priorities, new program development, political action, and the structure of rural clinics.) Task force groups assessed the feelings of board(s) and staff in regard to each issue. To do this, each group used a three-part process. The first step was to define the "ideal" without consideration of any constraints. The second step was to identify constraints and limitations. The final step was to make specific recommendations in light of the ideal spelled out in the first step, and the constraints spelled out in the second step. The recommendations of each task force were then reviewed in a general session of the advisory council.

3. Review of evaluation results by the central office--staff from the central office reviewed all task force recommendations, assigned tasks to the central office staff, and formulated an agency plan for the coming year.

FINDINGS OF EVALUATION OR MONITORING

Analysis of data from the local service areas suggested that there was a general need for alcohol and drug abuse services, services for high-risk families and children, and residential treatment programs for adolescents.

RECOMMENDATIONS

Each of the six task forces of the advisory board compiled a series of recommendations. Some of the recommendations included:

- Clarifying the council's role
- Establishing community committees
- Establishing a residential treatment program for adolescents
- Appointing a task force to develop a training packet for paraprofessionals
- Providing a greater opportunity for direct communication among satellite office managers

STEPS TO ENSURE IMPLEMENTATION

Responsibility for implementation rests with the center director. However, the advisory council continues to monitor implementation in its watchdog capacity. It has, from time to time, expressed concern over specific matters to the director of RCCMHC.

EXTENT OF IMPLEMENTATION

Implementation has been built into the evaluation process. The annual plan cannot be finished until the recommendations arising out of the annual evaluation meeting are received. After the central office reviews the evaluation data, many changes, particularly in the ordering of priorities, are made and plans for major innovations commence. But when major funding changes are called for, the process tends to be lengthy. Ultimately, some programs, such as the rural treatment center for troubled adolescents, must await legislative action and probably a change in the current economic climate.

SPECIAL BARRIERS OR SUPPORTS

The distances between population centers are a barrier to major citizen participation in rural areas. Communication between areas has been limited to representation of each area on the advisory council and to communications with the central office. Also, time limitations have constrained activities in some areas. But evidence of support for the evaluation was the high citizen commitment to RCCMHC; its services are not paralleled by the private sector. As a result, the citizen interest is real and, with diminishing State funds, the interest is accompanied by a sense of urgency. The staff of RCCMHC view the citizens of Nevada's rural communities as the primary support for the continued delivery of publicly funded mental health services. Without the willingness of citizens to serve as advocates for mental health services throughout Nevada's rural counties, the program would quickly falter. For this reason, the center staff accept the importance of an evaluation model that relies on citizen participation. Satisfaction, dissatisfaction, and desires are received with all seriousness. Also, citizen involvement has served to intensify the level of commitment to the center. On the other hand, citizens' participation and impact is appropriately diffused so that final recommendations reflect a collective consensus rather than the views of a few individuals who may be outspoken.

RESOURCES AND COSTS

Because evaluation is an ongoing part of the rural clinics' life of RCCHMC, the expenditure of human resources and money is very hard to gauge.

The last annual evaluation session involved 23 staff members and 6 citizens for 2 workdays at an approximate cost of $5,300. Time and cost estimates are not available for the local advisory board sessions. The advisory council conducts its business in four sessions per year at a budget cost of $4,000. The six members spend a minimum of 1 full workday per session.

ADDITIONAL COMMENTS

Speaking as one of the citizens involved in the evaluation process, the author is heartened by the lasting impact that the evaluation process has had on the operations of Rural Clinics Community Mental Health Centers. The time spent has produced positive changes and has served to help assure the ongoing presence of mental health services for the citizens of Nevada. The absence of any adversary relationship in this model and the mutual regard and cooperative spirit in the review is a spirit that should be nurtured carefully in undertaking any similar venture.

23. Mental Health Association Evaluation of County Mental Health Services

Al Dekker

Mental Health Association, Sacramento Chapter

SUMMARY

In early 1981, a subcommittee of the public affairs committee of the Mental Health Association, Sacramento Chapter (MHASC) made eight site visits to seven agencies representative of mental health services in Sacramento County. The purpose of the visits was to assess problems and constraints in the system administered under contracts with the county mental health division. The subcommittee examined programs, rehabilitation activities, health and safety, accommodations, menus, and accessibility of the system. The results were compiled in a report that described what was being done particularly well, listed the problems that were identified, and recommended specific actions by MHASC.

TYPE OF ORGANIZATION

The public affairs committee of the MHASC is an advocacy group composed of members of the board of directors and other volunteers from the association membership. The chairperson is chosen by the president of the board. The site visit subcommittee was a volunteer group whose chairperson was appointed by the chairperson of the public affairs committee. The public affairs committee advises the board on public stands to be taken on mental health issues.

EVALUATORS OR MONITORS

The four members of the subcommittee conducting the evaluation were: an accountant, a former school teacher, a licensed vocational nurse, and a retired research and development manager.

REASONS FOR THE EVALUATION OR MONITORING

Prior to July 1, 1979, the University of California at Davis administered the mental health system for Sacramento County. After that date, the system was administered by the county mental health division through contracts with a number of providers. Data analysis for the 6 months following this transition showed that the average outpatient count decreased by 30 percent in comparison with the county for the preceding 6 months. This stimulated interest in assessing the problems and constraints of providing care in the new county system as a basis for focusing future efforts of MHASC.

LEVEL OF PARTICIPATION

The outpatient counts were obtained from the county mental health division and analyzed by a subcommittee member. Members of the subcommittee selected representative sites to visit and checklists were prepared. Two to four members participated in each visit. The subcommittee chairman prepared a summary report.

TARGET OF EVALUATION OR MONITORING

This study focused on seven agencies under contract with the county mental health division. The county has a population of 783,000. The agencies selected covered a broad spectrum of care:

For further information write Al Dekker, Secretary, Board of Directors, Mental Association Sacramento Chapter, 5370 Elvas Avenue, Suite B, Sacramento, CA 95819, (916) 456-2070.

- A crisis emergency center
- A neighborhood mental health center
- A children's inpatient unit at a private general hospital
- A children's outpatient unit at the same hospital
- An experimental program treating clients in an outpatient mode who are so disruptive that they are usually treated in a more expensive inpatient mode
- A residential care facility
- An integrated mental health rehabilitation program built on the social model providing services for those who require ongoing mental health treatment
- A board and care home (not under contract with the county)

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The issues addressed were the degree to which agencies adhered to the requirements of California law and the service delivery problems and constraints identified by agency supervisors or staff.

TECHNIQUES USED

The techniques used included site visits supplemented by a checklist for facility review. The checklist was prepared by the full subcommittee and covered the relevant requirements of the California Code. One side of a legal size sheet of paper contained information obtained in a prior telephone inquiry. The other side contained specific suggestions for observations to be made during the site visit. Supervisors and staff were interviewed during the visit. Discussions were held with clients at only one facility. At this site, a consumer-satisfaction survey was conducted with 46 clients.

FINDINGS OF EVALUATION OR MONITORING

Monitoring the number of outpatient visits in the entire system during the fiscal year 1980-81 showed no significant further change from the 30-percent decrease in visits that had occurred during the 6 months following the transition in administrations. Each of the agencies appeared to be clean, well-organized, and to be doing a creditable job. One was doing an outstanding job in publicizing its activities under the new system and had rebuilt the client load. Examples of problems identified by the interviewees are:

- Preventive mental health is not receiving sufficient attention in the schools.
- Children's psychiatric emergency services are unavailable.
- Transportation of children in daycare services is difficult to arrange.
- Peer counseling is lacking in junior high school.
- The crisis emergency center has no way of segregating disruptive clients in the waiting area and is unable to handle nonambulatory clients and clients under 18 years of age.
- Bus routes and times of operation are inconvenient for clients attending the neighborhood mental health center and bus passes cannot be bought in the neighborhood.
- More facilities are needed to bridge the gap between board and care homes and completely independent living.
- There is a shortage of counselors for those residences in which clients prepare for independent living.
- There is a shortage of jobs for clients.
- The California State hospital system treats only those clients with good prospects for rehabilitation (this means that the county must treat the long-term chronically ill, some of who are so agitated that they need to be under permanent care in institutions).
- The consumer satisfaction survey (conducted at only one facility) was remarkable for the rarity of strongly negative comments.

RECOMMENDATIONS

Recommendations were directed to the public affairs committee of the MHASC which endorsed the report and recommendations, and directed them to the MHASC board of directors, which in turn adopted them. The recommendations are listed in order of priority:

- Sample consumer opinion concerning problems and needed improvements in the mental health system.
- Work to obtain employment opportunities for mental health consumers returning to the community.
- Determine the extent of peer counseling in elementary, junior high, and high schools in the county and lobby for its inclusion where absent.

- Investigate whether preventive mental health programs exist in the schools of the county and if so, their quality, and lobby for their inclusion or improvement as necessary.

- Persuade school systems to develop teachers' awareness regarding resources available for handling family and other mental health problems.

- Assess the availability of children's psychiatric emergency services, examine various options for improving services, and lobby for selected approaches.

- Become familiar with client and provider problems of the board and care homes through discussions with agency representatives, case managers, and State licensing officials.

- Work to initiate a patient tracking system that insures continuity of care without infringing on clients' rights to privacy.

- Continue site visits and attempt to develop a relationship with the mental health advisory board that would involve joint MHASC and advisory board site visits (the mental health advisory board is a statutory advisory board that reports to the county board of supervisors, and is separate from the MHASC).

- Assess the extent to which the need for rehabilitation programs for long-term consumers of mental health services is being met and lobby, if necessary, for expanding these services.

- Study alternative ways of dealing with long-term, chronically ill clients who are so agitated that they need to be under permanent care in institutions, select approach, and lobby for it.

STEPS TO ENSURE IMPLEMENTATION

Recommendations were internal to the association.

EXTENT OF IMPLEMENTATION

The association has initiated a preventive mental health program in elementary schools. The program is titled the "I'm Thumbody" program, and is directed toward building self-esteem in second-grade students. Sampling of consumer opinion has been initiated at an additional facility. The county mental health division has developed a computer-controlled billing system that is the first element of a planned client-tracking system.

The recommendations for MHASC action were so extensive that only a few could be addressed with the limited number of volunteers. They do, however, provide an agenda for future work.

SPECIAL BARRIERS OR SUPPORTS

The only significant barrier occurred when an attempt was made to visit a board and care home that had been assessed fines by the State for violations of regulations. Because the proprietor did not permit the State visit, the subcommittee substituted a board and care facility whose owner/manager was acquainted with a member of the MHASC board of directors.

The subcommittee members were very important to the success of the project. They were very interested, worked hard, and, as a result of their inquisitiveness, a great deal was learned.

RESOURCES AND COSTS

A conservative estimate of the total time spent by the four volunteer members of the subcommittee is 175 hours. Very little staff time was involved. The subcommittee typed checklists and reports, but the staff reproduced them. Transportation was paid by the subcommittee members.

ADDITIONAL COMMENTS

The most important thing learned was that talking with management or supervisors and tours of the facilities are of limited value in disclosing some of the serious problems that can exist. The contract for one facility that gave us a very favorable impression was subsequently terminated for poor management and allegations that several clients were sexually assaulted by employees. Next time, it would be important to find a way to talk with clients, former clients, and/or families of clients. Perhaps 75 percent of the time should be devoted to this activity.

24. A Site Visitation Team's Assessment of a Coastal CMHC

Ralph E. Denty, Jr.

Area 34 Mental Health Advisory Council and Glynn County Mental Health Association

SUMMARY

During 1977-78, the Glynn County Mental Health Association (MHAGC) and the Area 34 Mental Health Advisory Council (MHAC) implemented a project to assess and evaluate the service delivery system of the Coastal Area Community Mental Health Center (CACMHC) which provides services to the Counties of Bryan, Camden, Glynn, Liberty, Long, and McIntosh in Georgia. Site visits were made to the center and interviews were conducted with center staff, selected public agency personnel and other persons in the catchment area. These interviews and visits resulted in the development of a formal report that summarized the team's findings and recommendations.

TYPE OF ORGANIZATION

The Mental Health Advisory Council (MHAC) consists of 30 members drawn from the counties served by the CACMHC. The members are appointed by the director of the Georgia Division of Mental Health after nomination by the local health officer and the approval of the State Mental Health and Mental Retardation Advisory Council. The MHAC, whose composition complies with State standards for age, sex, place of residence, and income level, meets bimonthly and is responsible for approving the CACMHC's budget, hours of service, and selection of center director. The Glynn County Mental Health Association (MHAGC) is composed of interested citizens who, through their support, leadership, and advocacy, develop programs and disseminate information to promote mental health in the community and to ensure that adequate services are provided for the mentally ill.

EVALUATORS OR MONITORS

This evaluation was conducted by twelve volunteers from the Glenn County Mental Health Association (MHAGC) and MHAC. These individuals included a county commissioner, two ministers, a college professor, a school teacher, a doctor, a social service worker, a funeral director, and the executive secretary of the MHAGC.

REASONS FOR THE EVALUATION OR MONITORING

As an advocacy group, MHAGC felt a responsibility to determine if the services provided by the CACMHC were adequate to meet the mental health needs of the citizens in the catchment area. One of the mental health association goals is to evaluate periodically the services provided by the center. It was also felt that the advisory council should be included as a participant in the evaluation.

LEVEL OF PARTICIPATION

Project members were involved in every stage of the evaluation--from planning to assessment. Members were trained and equipped with the information, skills, and attitudes needed to conduct the study. All interviews, data collection, data analyses, and report writing were conducted by the members. When requested, secretarial and professional assistance were provided by the center.

TARGET OF EVALUATION OR MONITORING

The purpose of the site visitation project was to evaluate the delivery of services by a regional mental health center to a six-county, coastal area of Georgia. Services provided by the center include outpatient, day treatment, emergency, consultation and education, drug abuse, alcoholism, screening, followup, child and adolescent treatment and supportive living. A satellite program in Liberty County provides services for outpatients, children, adolescents, and drug and alcohol clients. Training centers for mentally retarded persons are located in four counties, and two counties have an outreach program of supportive counseling and followup medication for outpatients.

The center has a catchment area population of 104,000 and a median family income of $7,289 with 19.1 percent of the families receiving a yearly income of less than $6,000. Approximately 2,523 families (8.2 percent) are on public assistance. Administratively, the center is responsible to the local health officer and the

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Glynn County board of health, which is the contracting agency for the center's services. The health officer, in turn, is responsible to the directors of the Georgia mental health division and the physical health division.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The major areas assessed by the site visitation team included the following: the quality of communication between the CACMHC and the agencies and citizens served; the continuity of care; the degree of citizen involvement in onging policy determination of center programs; the implementation of all minimum required services; the time frame and procedures for adding new services; and the accessibility of services provided by the center.

TECHNIQUES USED

Information for this evaluation was obtained through site visits to the CACMHC and interviews with center staff. Interviews were also conducted with a wide range of key informants, i.e., knowledgeable community individuals including school principals, counselors, regular and special education teachers, Junior College students, policy department personnel, judicial members, lawyers, public service agency staff, physicians, a director of the emergency room at the local hospital and a random sample of citizens from the catchment area. *The Working Manual of Simple Evaluation Program Techniques for Community Mental Health Centers*, published by the U.S. Department of Health and Human Services (DHHS) in 1976, was used as a guide in conducting this research; the survey instrument contained in the manual served as a basis for the interviews.

FINDINGS OF EVALUATION OR MONITORING

The site visitation team was impressed by the high quality of services offered by the CACMHC and by the staff's commitment to their clients. It was discovered, however, that more publicity and better public relations were needed in order for the community to become more aware of the center, its location, and services. Those who were familiar with the center felt that the services provided were good and should be continued; however, the need for better public relations was also expressed. In counties other than Glynn, communication between the center and the public was even more limited. The center appeared to be best utilized in providing services to students with learning disabilities.

The team found that center staff put forth a great deal of effort to make sure that clients received continuity of care. Despite this effort, when patients were released from the regional mental hospital in Savannah, there appeared to be a breakdown in communications between the State hospital and the center. Moreover, partial hospitalization for mentally disturbed patients was not available in the local hospital. In addition, certain geriatric services and a formalized consultation and education program were not available at the center. In Liberty County the services were also limited, and there appeared to be some operational problems in providing services for Fort Stewart military personnel and their dependents.

Team members found that the center is physically, psychologically, procedurally, economically and culturally, accessible to catchment area residents. On the other hand, it was the team's general impression that the center is not physically accessible to all residents in the catchment area. Even though some services are provided at least 1 day a week in each county, there are problems with transportation and the services seemed to be limited in scope.

RECOMMENDATIONS

The site visitation team made the following recommendations:

- A coordinator for consultation and education should be employed.
- The center should secure a coordinator to be based in the regional hospital in Savannah to supervise admissions from the catchment area. A consortium of pertinent Fort Stewart personnel and center staff should be formed to develop plans of action in order to meet the mental health needs of Liberty County residents.
- The center should secure the services of a planner and grants officer who could do the forward planning to meet the anticipated needs of areas such as Camden County where the Poseidon submarine terminal is now located.
- The center should employ a business manager.
- The alcohol and drug abuse facility should be operated on a 24-hour-a-day basis.
- A coordinator for the Hinesville operation should be appointed.
- Staff vacancies should be filled as soon as possible, particularly that of the coordinator of the alcohol and drug abuse center.
- The center should explore methods of increasing awareness and visibility of its services in the outlying counties through a vigorous, ongoing public information program.

- Consideration should be given to expanding the center's transportation program, especially in the outlying catchment area.

STEPS TO ENSURE IMPLEMENTATION

After the study was completed, a formal written report was submitted to the CACMHC. This report was then forwarded to the State mental health office for the purpose of gaining additional support for funding of needed staff positions and programs. A copy was also provided to the State Mental Health and Mental Retardation Advisory Council.

EXTENT OF IMPLEMENTATION

To date, all but two of the recommendations have been implemented. A coordinator to be based at the regional hospital in Savannah has not been designated, and the transportation problems of persons in the outlying catchment area have not been resolved; however, some attempts have been made to ease these difficulties.

SPECIAL BARRIERS OR SUPPORTS

This study was greatly aided by the guidance and cooperation offered by the CACMHC staff. Such assistance included training inexperienced team members on the application of national requirements and standards in mental health centers. The major barriers were the team members' limited time and the large size of the catchment area. Since team members lved in different communities, it was difficult for all members to meet on a regular basis to implement the study.

RESOURCES AND COSTS

Each of the 12 team members donated approximately 25 hours to the evaluation. The CACMHC provided clerical assistance and necessary supplies to conduct the research and to print the final report (the estimated cost was $1,000).

ADDITIONAL COMMENTS

All of the individuals involved in this evaluation felt that the project was worthwhile, especially in view of the successful implementation of the recommendations. Another evaluation was completed in February 1983.

25. A Children's Committee Evaluates an Emergency Shelter Program

Joan Woolley and Dorothy Kurjan

Joint Children's Committee, Western Massachusetts

SUMMARY

Contracts for several programs funded by the Massachusetts Department of Mental Health (DMH) to provide services for children in a Massachusetts county were up for renewal in the spring of 1982.* In order to make a sound recommendation on the disposition of these contracts for the department of mental health, the children's committee of a Massachusetts area mental health board decided to evaluate the programs by conducting site visits and interviewing staff and other appropriate persons. One program in particular, The Shelter, presented special concerns to the evaluators.

For further information write Joan M. Woolley, M.S.W., LICSW, c/o DMH District Office, Northampton State Hospital, Northampton, MA 01060, (413) 584-1644.

*Because of the circumstances surrounding the outcome of this case, the specific location of the program evaluation is not identified in order to ensure confidentiality of the program.

TYPE OF ORGANIZATION

The establishment of a children's committee in each DMH catchment area is mandated by State law to review ongoing services for children funded by the department, to assess needs for new programs and to advise the department of its findings. At the time of the evaluations, the children's committee was composed of 11 members--four on the area mental health board, and seven others (area mental health board members are appointed by the Governor). Each member participating in the evaluations had an interest in, and commitment to, children.

EVALUATORS OR MONITORS

In the spring of 1982, the children's committee consisted of providers of children's educational and social services, board members of various human service agencies, a probation officer, and a city councilwoman. Three members of the children's committee were directly involved in the evaluation of The Shelter: the chairperson, a

social worker in private practice and former director of a residential facility for moderately disturbed adolescent women; a member of the board of an agency serving adolescents; and a retiree who was formerly employed as a child advocate by the Massachusetts office for children and who now serves on boards of several human services agencies.

REASONS FOR THE EVALUATION OR MONITORING

The purpose of the children's committee is to make recommendations on existing children's programs to the area mental health board, which then advises the department on children's issues. Problems at The Shelter came to the attention of the committee because of a deep concern among child-serving professionals (some of whom were members of the children's committee) about the quality of the program and the stability of the agency.

LEVEL OF PARTICIPATION

The members of the children's committee participated in the following activities: development of a uniform method for investigating all the programs being evaluated; formation of two separate four-member teams for each program evaluation (each team conducted one or two site visits); and preparation of written reports that were submitted to the children's committee and the area board. In the case of The Shelter, the evaluating team recommended that a new contractor be selected. This action required the children's committee to meet with the three agencies that submitted proposals to take over the administration of the program. A report describing the rationale for changing the program's contractor was written by the evaluation team and presented to the area board.

TARGET OF EVALUATION OR MONITORING

The target of the evaluation, The Shelter, is an emergency shelter for adolescents in crisis situations who need a temporary place to stay and an atmosphere of caring. The other objectives of the program are to assess the problems of these young people and their families, to offer remedial assistance, and to work with other community agencies in making placement decisions concerning the adolescents. At the time of the study, a regionwide agency had a contract with the department of mental health to provide youth services of these kinds. The Shelter, located in a Massachusetts city with a population of approximately 50,000, is the only emergency shelter for adolescents to serve a largely rural county containing a population of 145,000 and an area of 947.14 square miles.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The evaluation process concentrated mainly on the quality of services delivered to adolescent clients by one specific agency--The Shelter. After determining the goals of the program, the primary focus of the evaluation was on programing for the client, that is, from intake procedures to case disposition and followup. Administration, staff, physical plant, and use of community resources were analyzed in terms of how these components assisted in the implementation of stated program goals. Clients' rights as well as the rights of biological or foster parents, where applicable, were also deemed important in the evaluation. Finally, problems with staff turnover and low morale were major concerns that observers felt could be attributed to the contracting vendor.

TECHNIQUES USED

The children's committee developed its own evaluation and monitoring procedures. The program director of The Shelter was asked to submit a statement of the program goals, descriptions of the client population, and staffing patterns, and the director's perceptions of the program's strengths and weaknesses. Site visits were made by the evaluating team and included interviews with the director and several staff persons and observations of clients in the program. When the evaluation report was completed, it was sent to the program director and an "exit interview" was scheduled with the director to discuss the findings and to obtain feedback from the program staff about the evaluation.

This was the first time that the children's committee had completed a formal evaluation of DMH-funded programs, and the technique proved useful. Although the committee has made some revisions in the questionnaire, the basic format of the instrument will not change.

FINDINGS OF EVALUATION OR MONITORING

At the time of the evaluation, the program director of The Shelter had been in that position for approximately 6 months. He used this period of time to strengthen the administration of the program and to regain credibility in the community. The contracting vendor, however, was not very helpful in these efforts. For example, the evaluating team found that there was inadequate backup staff available to the program, that is, regular line staff had difficulty taking sick leave, vacations, and time off for training. Staff backup and support were often missing during times of crisis, which are frequent when dealing with troubled adolescent populations. In general, the vendor was not providing adequate clinical and

administrative supervision and support to the program staff.

In addition, the evaluating team found that the family coordinator position could be made more effective by changing his or her available hours to coincide with the out-of-school time of The Shelter's residents. The team also found that clinical supervision for the program's family counselor was lacking.

Other team findings focused on funding issues. For example, all of the staff were greatly underpaid, which was primarily a result of inadequately funded contracts. On the other hand, the evaluating team had questions about the amount of administrative costs of the program in relation to the actual services provided by the vendor. The multifunding sources of the program, including the State department of social services and the department of mental health, United Way, the city and county, and a private agency also presented many problems. With little coordination among the six funding agencies, staff energy and time were siphoned off from program activities into time spent on additional bureaucratic functions.

RECOMMENDATIONS

The team's major recommendation was not to renew the current vendor's contract to provide an emergency shelter. As suggested by the team, the department of mental health should contract with a vendor who could provide the following: a staffing pattern that would include an efficient division of responsibilities, strong clinical backup for program staff, clinical staff backup and support at times of crisis, well-developed staff training programs, and strong supervision and backup from the vendor. Further, the evaluating team strongly recommended that a system of communications and joint monitoring and evaluation be established among the funding agencies.

STEPS TO ENSURE IMPLEMENTATION

The committee has considerable authority to implement its recommendations since the department of mental health reviews those recommendations before determining which programs will continue to be funded. In addition, the entire children's committee will meet with the new vendor from time to time, and the evaluating team will visit the program periodically during the year.

EXTENT OF IMPLEMENTATION

The team's primary recommendation that the contract with the current vendor be terminated was implemented. Subsequently, a new vendor who met the evaluation criteria of the children's committee was awarded the contract to administer the emergency shelter.

Another recommendation concerning multi-funding sources was also implemented. When the contract was transferred to a new vendor, a meeting was held involving all six funding sources, the outgoing and incoming vendors, and members of the children's committee. The purposes of this meeting were to ensure a smooth transfer from the old to the new vendor, to make sure that all concerned parties had a clear understanding of the goals of the emergency shelter, and to encourage cooperation among all parties.

SPECIAL BARRIERS OR SUPPORTS

The emergency shelter staff responded positively to the evaluating team. In addition, the area mental health advisory board was most supportive of the evaluation, as well as the area DMH director who welcomed the evaluation.

It was important that each team evaluating childrens' or adolescent programs, including The Shelter, was made up of professionals from areas such as special education, social services, city government, the court system--to name a few--plus concerned, aware citizens. Since the children's committee is a volunteer group, securing adequate time from the citizens and coordinating team schedules was difficult, but not impossible, to accomplish.

RESOURCES AND COSTS

The evaluating teams spent approximately 3 months on the program reviews including preparation, site visits, team discussions, writeups and concluding interviews. An average of 25-35 hours per individual was spent on each program review including The Shelter. The entire children's committee met once a week during this time, and the teams met as needed. Other direct costs, such as typing and reproducing efforts, were absorbed by area department of mental health staff.

ADDITIONAL COMMENTS

The children's committee found that a program needs to undergo a rigorous evaluation every 3 years, with followup site visits and interviews with all committee members. In this way, the area board will become aware of potential problems and how to resolve them before the program is adversely affected.

Committee members also feel that it is important to have an evaluation specialist conduct several training sessions on interviewing techniques. In addition, the committee recommends that a mix of professional and concerned lay citizens always be used when forming evaluation teams. Further, the children's committee believes it is important for any evaluation team to stress the positive aspects of a

program and to determine how community advisory committees can most effectively assist programs toward goal achievement and provide ongoing support.

The evaluation efforts of the children's committee made both the committee and the area mental health board more credible and visible within the county. It also made the DMH-funded providers more vigilant regarding the quality of the services they deliver to children.

26. Evaluation of GCMHC Adult Outpatient Services' Group Orientation Procedure

Jan Foutz

Citizens' Advisory Council, Granite Community Mental Health Center

Barbara K. Goza

Salt Lake County Division of Mental Health

SUMMARY

The citizens' advisory council and Granite Community Mental Health Center (GCMHC) staff and management collaborated in the evaluation of one program component within the center. The question of interest was the cost and effectiveness of a newly initiated group format for orientation of clients to adult outpatient services.

Three different methods of analysis were used: analysis of complaint files, retrospective review of client flow through the system, and client satisfaction with the orientation. Generally, the group orientation procedure was found to be cost effective; however, there were some problems that needed to be addressed. Implemented recommendations for change included: job redesign for the screeners to facilitate identification of clients needing more immediate help and preparing others for the group experience, and additional orientation meetings and child care services to improve the referral system.

TYPE OF ORGANIZATION

The evaluation was conducted by the citizens' advisory council for the community mental health center, in collaboration with center staff and management. The 20-person council was composed of interested community members, appointed with the approval of the county commission which serves as the governing board of the center. The advisory council considers itself an advocacy group--both for the center and for the community it serves. Membership in the council is determined by professional skills, special interest in mental health (such as consumers or families of consumers), or general interest in mental health issues.

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EVALUATORS OR MONITORS

Planning and implementation of this project was accomplished primarily by advisory council members, with the support of the center's evaluation staff. The chairperson of the task force had primary responsibility for the project. This included focusing the research questions, interpreting data, recommending changes on the basis of the data, and facilitating the implementation of recommended changes. At that time, the chairperson of the task force had no formal training in evaluation research. Other advisory council members who assisted in planning and data interpretation were two psychologists employed by other human service organizations, and a person who worked in the billing office of the center and who volunteered to perform the telephone survey in addition to her regularly scheduled work requirements. This person was taking a course in research design at the time and was able to use this hands-on survey experience to fulfill class requirements. Center evaluation staff assisted with the design and data analysis.

REASONS FOR THE EVALUATION OR MONITORING

GCMHC had tried an individual approach to orientation of clients to center services and had been dissatisfied with the failure of this program to reduce the frequency of broken appointments. The adult and family outpatient unit started a new orientation process to try to maximize staff involvement with clients and to maintain appropriate services to clients. This new program used a group format. One year after the program had been implemented, there were some client complaints from a person (or persons) who felt s/he was asked to attend a group orientation when s/he was in crisis and should have received clinical attention more quickly. In keeping with the philosophy of the center, the executive

director informed the advisory council of the complaint. The unit manager asked an advisory council member to chair a committee to plan research to examine the extent of the problem and potential solutions.

LEVEL OF PARTICIPATION

The advisory council was very much involved in planning the three-pronged approach to the research. Council members selected the research question, reviewed proposed research designs, and established project timelines. Center evaluation staff analyzed complaint files and data on client flow through the intake system. A student volunteered to conduct a telephone survey of consumers. The advisory council was responsible for compiling these three sources of data, developing a trusting relationship with the team leader responsible for this program component, interpreting the data, and making recommendations for change.

TARGET OF EVALUATION OR MONITORING

The target of this research was the adult and family outpatient services unit in Granite Community Mental Health Center in Salt Lake City, Utah. The agency is located in an urban community and treats clients on an outpatient basis with individual and group psychotherapy. A broad range of client problems are treated, including family conflict, depression, alcohol and drug dependency, and more chronic conditions typically encountered in urban settings. The specific aspect of the evaluated unit was a newly initiated group format for client orientation. The group format had been planned in an effort to provide a more cost-effective procedure for adequately disseminating general information about GCMHC services and alternatives. It was hoped that the orientation would reduce the number of scheduled intake appointments not kept. Center management and the advisory council were interested in determining whether these objectives were being met, particularly for low income and minority clients.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The general issue evaluated in this study was the effectiveness and appropriateness of a newly initiated group format for orienting clients to center services. First, the number of client complaints concerning this new format was compared with the number of complaints arising from the previous format that utilized individual orientation sessions. Second, appointment followthrough rates for clients attending individual and group sessions were compared. Third, client satisfaction with the new format was examined.

TECHNIQUES USED

Three separate techniques were used in this study. Two of these techniques involved analyzing data that were already available at the center. One involved the collection of additional data. Data on client complaints were obtained from an ongoing file of complaints maintained by the center director. The number of complaints received during each of the 6 years prior to, and 1 year following, initiation of the group orientation program was compared. Appointment follow-through rates were calculated by analyzing data from the center's client information system. A member of the center's research staff reviewed data on client flow from initial call to first treatment session. All clients scheduled for individual intake sessions and for group orientation meetings during the previous 1-year period were compared with regard to appointment followthrough. Finally, client satisfaction data were collected by means of a telephone survey. A member of the center's billing staff volunteered her time to conduct the telephone survey. An attempt was made to interview all 37 clients scheduled for group orientation sessions during a 2-month period. Interviews were conducted 2 or 3 months following the scheduled orientation sessions.

FINDINGS OF EVALUATION OR MONITORING

Several findings emerged as a result of this three-pronged evaluation. The first was that the number of client complaints had not increased following the introduction of the group orientation format. Secondly, the available data from the client information system indicated that the proportion of clients keeping their first treatment appointments following group orientations was at least equal to, if not greater than, the proportion of clients doing so after individual intake sessions. In addition, the client tracking data suggested that male clients were more likely to attend their scheduled orientation sessions than were female clients.

Findings from the client satisfaction survey presented a somewhat more complex picture. Of the 37 clients scheduled for group orientation sessions, 20 had attended. The two major reasons for nonattendance were conflicts with work schedules and the clients' perceived needs for more immediate clinical attention. Clients were asked to rate various aspects of center services in general, and the orientation sessions in particular, using a Likert-type scale. This question format asks clients to respond to items using a scale with intervals ranging from very negative to very positive. In the present case, a seven-point scale ranging from poor (1) to excellent (7) was used. When clients were asked to rate the change in their presenting problem since contacting the

center, the mean response of those who did and did not attend their scheduled orientation sessions were equal and indicated slight improvement. Clients were not satisfied with the extent to which their questions regarding center services were answered. They were somewhat less satisfied with the extent to which their specific questions/concerns were addressed. A somewhat less than neutral response was given to the question regarding the atmosphere of the orientation. When asked what would have made them most comfortable, 55 percent of respondents reported a need for more privacy for discussing personal problems. An additional 30 percent reported that nothing would have helped, that "it's just difficult to ask for this kind of help." Of the 20 respondents who attended the group sessions, 11 were given intake appointments, 3 were referred to private clinicians, and 6 reported not being given specific suggestions for referral.

RECOMMENDATIONS

The conclusions drawn from these data were that the group orientation procedure was cost effective from the perspective of staff deployment. However, there seemed to be a number of changes that might be made in order to meet the needs of the clients more adequately. These changes were:

1. To expand the scheduled group orientations to alternative times (perhaps evenings) to alleviate work schedule/child care conflicts.

2. In order to improve accessibility to women, screening staff should be sensitized to the needs of women attending orientation sessions, and child care services should be considered.

3. Screeners should prepare clients extensively for accurate expectations of the orientation meeting, especially that it will not involve much personal sharing. The orientation sessions should be kept small. More staff should be available so that the clients can break into smaller groups of four or five for discussions.

4. The problem that some people do not have a clear idea of alternatives for help following the orientation session should be addressed by: providing more individual attention and support in looking at alternatives; having intake hours available right after the orientation session so that those who do not want to wait can go right into intake; and by improving the referral system through improved communication between the agency and private practice clinicians.

5. The issues of payment and fees may be of such a different quality than issues of treatment and services, that it might be good to have the two orientation staff members divide discussion of these issues between them.

6. While the data from these studies do not directly address problems of low income or minority clients, the client flow data, indicating greater followthrough by men may be an indication that the orientation meetings are more effective for individuals socialized into the white male culture. This points to the importance of continued sensitivity to cultural issues in the screening process.

STEPS TO ENSURE IMPLEMENTATION

The steps considered to be most important to ensure implementation were: early involvement of the staff and management of the unit being evaluated; development of communication and trust between the advisory council members and the first level of supervision for the program component; and feedback and discussion of data generated in the evaluation by the unit staff and management. Since the recommended changes were under the control of unit management and staff and the suggested changes were implemented, it was not considered necessary to publish these data outside the center.

EXTENT OF IMPLEMENTATION

Many of the recommendations from this research process were acted upon by unit staff and management. The unit assigned two persons to share the screening responsibilies so that they would also have the opportunity to participate in other forms of therapy, thereby avoiding reduction of their work routine. This job redesign was considered helpful in keeping screeners' attention focused on the special needs of clients. A child care service, staffed by volunteers, was begun by the volunteer coordinator and was available during the hours of the group orientation. A series of open house meetings between private practice clinicians and center staff, management, and the advisory council, was organized and run by the advisory council. The council chairperson of this research felt that the recommendations were implemented as much as possible by the center.

SPECIAL BARRIERS OR SUPPORTS

Several factors supported this evaluation. The responsive management that initiated the research indicated a readiness to use evaluation data. It was very important to have representatives of the advisory council, the service delivery system, and research and evaluation staff

involved in the planning and disseminating phases of the research. Perhaps most important, the advisory council has established trusting relationships with management which greatly facilitated their collaborative work. Trust building takes time, but since evaluation can be threatening, it is a critical step to take before any negative feedback can be given in a constructive way. It was also valuable in this research effort that the chair of the advisory council committee was a lay person inexperienced in research. Her questions about how the research design would answer the questions were of real value. Another characteristic of this committee which contributed to implementation of the recommendations was that the members were in no way "yes" people. They were able to be verbal, interested, and supportive, but supportive in a challenging way.

The only barrier to the work was the difficulty in understanding the client flow data, given the relatively large number of persons "lost" from the system. However, this barrier became the stimulus for further research and for improving the client tracking system in the center.

RESOURCES AND COSTS

The amount of time contributed to this research was approximately: 250 hours for advisory council members in planning and implementing the evaluation; 160 hours for evaluation staff in reviewing complaint and client tracking data and providing consultation for the research; and about 100 hours from the student volunteer who collected the data for the telephone survey.

ADDITIONAL COMMENTS

In evaluating her involvement in this research, the chairperson of the task force thought that the research had been effective in improving service delivery. She had attended the group orientation both before and after the implementation of recommended changes and thought the process was much improved. Immediately after the screener job had been redesigned so that two persons were sharing these responsibilities, more clients began showing up for the group orientation and satisfaction with therapy increased. The chairperson also found the process helpful to herself, in that it taught her about management's goals and responsiveness as well as the basics of research.

27. A Descriptive Evaluation of Psychiatric Emergency Services in Two Hospitals: A Preliminary Study

Elizabeth Fulton and Bruce Hirsch

Mental Health Association of San Francisco

SUMMARY

This study was conducted by volunteers from the Mental Health Association of San Francisco (MHASF). The purpose of the study was to obtain a descriptive evaluation of psychiatric emergency services (PES) facilities through site visits to two San Francisco hospitals. The study focused on the ways in which the physical plant, staffing patterns and procedures at each hospital affected the PES mission of providing mental health services for persons in a psychiatric crisis.

TYPE OF ORGANIZATION

The Mental Health Association of San Francisco is a nongovernmental, nonprofit volunteer organization affiliated with the Mental Health Association of California and the National Mental Health Association. MHASF advocates for improved mental health services and seeks to educate the public about mental health and mental illness. The association is governed by a board of directors that is chosen from its 800 members who represent the cultural diversity of the San Francisco community.

EVALUATORS OR MONITORS

This study was carried out by MHASF's public affairs committee in cooperation with the directors of the hospital PES units being studied. The committee organized a group of eight volunteers to implement the evaluation including an attorney, three counselors, a mental health administrator, an insurance professional, a housewife, and an organizational consultant.

REASONS FOR THE EVALUATION OR MONITORING

The study was initiated as a result of MHASF

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discussions concerning long-range strategies for reviewing community mental health services programs in San Francisco. Members of the MHASF public affairs committee and board of directors recognized that psychiatric emergency services (PES) facilities serve as the hub for community mental health services since they provide triage and access to other programs. As such, it was vital to evaluate certain aspects of PES facilities.

LEVEL OF PARTICIPATION

Volunteers prepared and submitted a formal proposal to the San Francisco Department of Public Health requesting permission to conduct the study. They also conducted a lengthy review of regulations governing the operation of the PES facilities. The eight members of the visitation task force worked with the public affairs committee in designing the data collection instrument and in issuing a final report; they also worked with the directors of the two PES units and their staffs in implementing the evaluation.

TARGET OF EVALUATION OR MONITORING

The study covered two PES units that are part of the community mental health services network serving the city and county of San Francisco: the San Francisco General Hospital PES and the Westside Crisis Clinic at Mt. Zion Hospital. San Francisco General Hospital is located in an ethnically diverse, low income area: it covers more than one catchment area and handles the overflow of clients from other districts. The predominant population groups using this crisis unit are white, black, Hispanic, and Chinese. Mt. Zion hospital is located in a predominantly low income area although its catchment area also includes some high-income sections. Major client groups using the PES unit at Mt. Zion are black, white, Chinese and Filipino.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Psychiatric emergency services serve as the entry point of the mental health treatment system for people experiencing a psychiatric crisis. On the basis of site visits, this study sought to evaluate the following: the ability of PES units to meet minimum standards for pleasantness of physical surroundings such as lighting, decor, and availability of reading materials; ability of these units to cope with a sudden influx of patients; actual client contact; stressfulness of intake procedures; noise level, ventilation, and temperature; condition of seclusion rooms and restraining equipment; staffing patterns, including sex, ethnicity, and linguistic capabilities; and average time spent with clients.

TECHNIQUES USED

Volunteers first met with each PES facility administrator in order to become familiar with the operation of the units. Next, they reviewed regulations governing the operation of the facilities and developed a checklist to be used to evaluate the units during site visits. Checklist items included dates and times of patient visits, available physical equipment, staff structure, availability of staff, and patient information. Patient information included date of entry, ethnicity, age, sex, and entering condition as observed by volunteers. Site visits were scheduled during known periods of stress when people would be inclined to seek out the services of a service unit. Finally, summaries of the visits were produced from data recorded on the checklists.

FINDINGS OF EVALUATION OR MONITORING

The study produced the following findings: (1) it strengthened MHASF recognition of the central role of psychiatric emergency services (PES) in the public mental health delivery system; (2) it highlighted the importance of using non-English-speaking clinicians in a culturally diverse city like San Francisco; (3) it increased the mental health association's respect for and understanding of PES staff; and (4) it highlighted the severe space limitations at one unit that made it difficult to handle an influx of clients.

RECOMMENDATIONS

The results of the general site visitation suggested that there was a need for a followup study to identify the availability and appropriateness of referrals for persons entering the mental health system through the PES units. Also, it was recommended that the physical space problems at one unit be addressed. This recommendation was made to the director of the unit and was supported by city officials, including the program chief of community mental health services and the director of the department of public health.

STEPS TO ENSURE IMPLEMENTATION

In order to ensure that the followup study would take place, MHASF and the directors of the crisis units worked together in planning the new study. The association continues to evaluate and monitor other community mental health services programs and to support efforts to provide more physical space for crisis units. MHASF representatives have observer status on the community advisory board for San Francisco General Hospital and have been given a regular place on the monthly agenda.

EXTENT OF IMPLEMENTATION

The followup study was conducted and is described in Chapter Six of the Casebook. Moreover, the new and expanded PES unit opened in July, 1982.

SPECIAL BARRIERS OR SUPPORTS

Some volunteers were unfamiliar with the operations of psychiatric emergency services (PES) facilities and the mental health treatment system. On the other hand, hospital officials were very helpful and seemed to welcome the objective of the volunteers. The director of one PES has established a strong ongoing relationship with the Mental Health Association of San Francisco (MHASF).

RESOURCES AND COSTS

Planning the study took several months, and site visits were conducted by eight volunteers over a period of 4 days. Visits were arranged to cover a representative sample of all times of the day. Volunteers were supported by MHASF staff as part of its ongoing public affairs program.

ADDITIONAL COMMENTS

The study showed that data collection by volunteers can be important and useful to the professional community. One important lesson learned from this experience is that a single program may require more than one evaluation effort.

What Will Be Your Focus?

The decision regarding the scope of the evaluation has now been made, and Doug Brown and his committee must now decide the issue of topics they will address during the course of the study. They know that they are concerned with service delivery across county programs, but they need to develop a perspective from which to view the system. It will be from this perspective that research questions can be developed and a subsequent research strategy can be designed. One of the committee members mentions that any evaluation activity aimed at long-range planning will have to take into consideration the State's plans for the future of Riverview State Hospital. On further investigation, Doug confirms that State officials are planning to close a wing of Riverview State Hospital during the next fiscal year. This is particularly significant for Greene County since the unit slated for closing houses a majority of county residents. Although services in the community have expanded and improved during the past several years, it is not clear whether the county program can rapidly absorb more seriously disabled, long-term institutional residents. It seems clear to Doug and the committee that their analysis should focus on the issue of deinstitutionalization and that the research should be designed with this topic in mind.

Having selected a topic or issue to explore, Doug and the committee members must now decide what aspects of the issue are of particular concern to the mental health system in Greene County. By going through this process they can isolate the questions to be answered by the evaluation and can therefore determine what steps they will take to get the answers. After conversations among themselves and staff at the county level, they decide to explore the following problem areas:

To what extent are services available in Greene County to meet the needs of current residents at Riverview State Hospital?

What new services need to be developed to meet these needs?

To what extent will county residents resist the placement of formerly institutionalized persons back into the community?

Are administrative procedures established between county program staff and institutional staff to ease the transiton?

Has an adequate amount of money been allocated to follow former residents back into the community?

The cases included in this chapter cover a wide spectrum of topic areas, from funding issues to a concern about the proposed closing of a State facility. The diversity of areas shows the breadth of topics and issues that can be addressed by citizen and consumer groups.

Needs Assessment

The first case, by Lois Van Valkenburgh, relates the efforts of the Alexandria (Virginia) Community Mental Health Center's governing board to assess community needs in preparation for the following year's program planning. In addressing which issues should be covered by the needs assessment, board members, together with staff, identified the critical areas. The board focused on four major issues: truant youth, outreach to minorities (especially important given the recent influx of Indochinese refugees in the area), outreach to the elderly, and supervised residences for the chronically mentally ill. Interviews were held

with key informants in the area, and the board worked with the center's evaluation staff to develop recommendations and prepare a report.

Administrative Priorities

Ed Diksa of the Sonoma County (California) Mental Health Board discusses that board's role in providing citizen participation in the county's mental health planning process and in approving the process whereby the plan is adapted. During the review, two major issues were investigated--budget cuts and friction between agency staff and the director. It is interesting to note that board members felt obliged to respond to staff morale and quality issues as part of their mandate to evaluate and plan for county services. Meetings were held with administrators and program directors, community services, and staff. Results were reported to the mental health department and the county board of supervisors.

Facility Concerns

Jan Holcomb, Ann Nerad, and Karen Helfrich of the Mental Health Association of Greater Chicago discuss the work of that organization's site visitation committee in monitoring care at six State mental health hospitals. Individual interest in monitoring the facilities, as well as continuing media coverage of the inadequacies of the State hospitals, prompted association volunteers to focus their review on specific aspects of the facilities. Site visits cover a wide range of issues, from policies and procedures to housekeeping, staff attitudes, and residents' rights. Trained volunteers directly observe and interview patients and conduct interviews with staff and administrators. They report findings and recommendations to the facility superintendent, share information with the Illinois Guardianship and Advocacy Commission, and, in one case, the press.

Funding and Resource Allocation

Two cases address the issue of how funding decisions are made. Jean Abruzzino and John Corrigan report on the sophisticated computer decisionmaking tool used by the Franklin County (Ohio) Mental Health Board to set service priorities and recommend allocations. The board, mandated by State law, is composed of area citizens who plan, recommend funding levels, evaluate, and oversee the development of services in the county that are delivered by contract agencies. Resource allocation decisions are only one aspect of the board's evaluation responsibilities, but in a complex and diverse service system, such as Franklin County, resource issues are of paramount concern and take an inordinate amount of board members' time. The case summary describes the use of a computer tool, the goal programming model, which provides greater flexibility to board members in their decisionmaking by analyzing the impact of various funding strategies and providing information on service availability, need, fiscal issues, and special constraints.

The second case concerning funding comes from Frances P. Meehan of the liaison committee of the San Gabriel Valley (California) Mental Health Association. As in Franklin County, it stresses the importance of understanding resource allocation issues. When the committee discovered a disparity between allocation of mental health funds to their area as compared to other regions in the county, they reviewed pertinent sections of the county budget and compared this to the size of the population and projected needs. A report on these issues was made to the county supervisor representing San Gabriel Valley, plus a number of civic and advocacy groups, since prior appeals to the county mental health department had been unsuccessful.

Service Delivery

The next case study, presented by Barbara Todd of the Fairfax-Falls Church (Virginia) Community Services Board, covers the work of a task force to explore whether systemwide consolidation of services could reduce costs sufficiently to maintain existing service levels in a time of reduced budgets. The task force conducted site visits, reviewed written materials, talked to staff, and generally undertook a very ambitious project. Perhaps the project was too ambitious, since very few of the task force recommendations were implemented. Results included an overview of how well clients were being served and the feasibility of systemic change.

Individual Rights

The Montana Mental Disabilities Board of Visitors reviews annually the State's community mental health centers, inpatient facilities for the mentally ill, and institutions for the developmentally disabled. Kelly Moorse writes that the board examines patient care and treatment, medication, recordkeeping, and consumer issues. Members conduct site visits at facilities, review treatment and medication plans, inspect residential and treatment areas, interview staff and patients, and respond to individual grievances from patients, family members, and the legal system. Ensuring that patients' rights are protected is of primary concern to the board. The board is an important vehicle for patients wishing to resolve individual complaints, and it also addresses client-right issues on a statewide level. Site-level findings are sent to the facility staff for comment prior to the preparation of a final report; however, individual grievances are evaluated immediately and options for change presented to the client and others involved.

Client Satisfaction

Joyce G. Smith of Hill House Mental Health Rehabilitation and Research, Inc., discusses a project whereby clients of a psychosocial rehabilitation agency designed instruments to assess client needs and evaluate client progress. The Client-Oriented Program Evaluation (COPE) group consists of current or former clients who provide evaluative information to both the staff and the board of trustees. In this example of consumer satisfaction, clients worked cooperatively with the agency's research staff to develop better measures of client needs and program evaluation. Clients were not passive reactors to the evaluation but instead participated in many complex tasks, including designing and testing survey instruments.

Special Populations

Two cases focus on evaluations of services to specific recipient groups, the chronically mentally ill and the aging. Cheryl Fanning of the Community Support Project (CSP), Arizona Department of Health, discusses the review by three advocacy groups of a community residential treatment system for chronically mentally ill individuals. A review of programs serving the chronic population was tied to the CSP staff's planning and budgeting responsibilities. The review enabled consumers to reflect on the quality of services provided to this target group. Reviewers conducted site visits to programs in seven cities, focusing on physical aspects of the residences and activities available, and they observed staff interactions with residents. Results were reported to the CSP and, in turn, to contract agencies.

The second case is reported by Margaret Munford of the In-Home Services Committee of the Washington County (Oregon) Council on Aging. She writes about the committee's evaluation of a mental health clinic's ability to serve elderly residents of nursing homes. The committee had jurisdiction because of its advisory role to the council on aging which, in turn, contracts with the clinic. In this particular case, the focus of an organization representing senior citizens in a nursing home program is self-evident. What is somewhat unusual is the use of a member of the senior citizens organization to evaluate such concerns as the quality of life of nursing home residents. The committee distributed a questionnaire to clinic staff, held consultations with nursing home supervisors, and attended a group therapy class. Findings of the evaluation were reported to the council on aging as it considered whether to renew its contract with the clinic.

Service Quality

Ruth M. Taylor of the Parent Monitoring Committee, Association for the Macomb-Oakland (Michigan) Regional Center, reports that the committee, composed of persons with relatives living in community group homes, has monitored over 90 group homes to date. Service quality issues are of foremost concern to this committee since it serves as the eyes and ears for all parents and for the service system as a whole. The committee's monitoring efforts also coincide with other quality assurance reviews implemented by the State. Monitoring site visits are made, an evaluation form filled out after the visit, and the report reviewed by a core committee. The committee focuses on quality of life and environment issues, health, nutrition, and client rights. Recommendations stemming from the site visits are made to the regional center, which contracts with the homes.

Planning

Each year, Marin County (California) Community Mental Health Services establishes citizen task forces as part of its planning process. Ralph W. Accardi, of the Older Adult Services Advisory Committee, Marin County Mental Health Advisory Board, reports that task forces make recommendations based on needs assessment, studies of service delivery, and evaluation of progress made towards implementing the previous year's plans. In this case, citizen involvement in planning is required by the State. It is also evident that Marin County staff, together with citizens, have made this part of a continuing process of planning and evaluation.

Another planning-oriented case is reported by David L. Silver and Donald A. Craig from Northeast Kingdom Mental Health Service, Inc., in Vermont. Silver, who chairs the program and evaluation committee of the agency's board of directors, and Craig, who is a staff planner and evaluator, describe the annual interviews with agency staff that are conducted by the committee. Again, the staff/citizen collaboration surrounding agency planning appears to influence the setting of goals and priorities for the community as a whole. Results from these interviews lead to recommendations to the board and later to the agency's administrative staff as they plan for the future.

Acceptability/Awareness

Kevin M. Kindelan, George F. Mailly, and Kathy B. Hayes, of Winter Haven (Florida) Hospital Community Mental Health Center, report on a key informant survey that was employed to determine perceptions of mental health needs as well as the agency's visibility, acceptability, and accessibility. The study was undertaken by the center's program evaluation and research committee and, as opposed to other cases in this book, involved citizens only in the role of survey re-

spondents. Respondents were identified as individuals in the community who were aware of its mental health problems and needs and worked in areas such as school counseling, social services, ministry, law enforcement, and homemaking. The use of a broad spectrum of knowledgeable individuals in the needs assessment provided agency staff with baseline data with which to conduct other targeted assessments (e.g., child-oriented key informants) in the future. Recommendations arising from this study were submitted to the center director.

Institutional Closure

William P. Benjamin, President of the Central Islip Board of Visitors in New York State, reports on the conduct of an evaluation of a proposal to close the Central Islip Psychiatric Center. The board, plus an ad hoc committee of employees, patients, and community residents, studied the type and level of care being provided patients at the center, analyzed the possibility of patients receiving the same care at other facilities, and evaluated the effects of relocation and transfer on patients. Data were gathered from key informant interviews, interviews with staff of that center and other facilities in the region, and a demographic study. Results were communicated to the State office of mental health, boards of other State hospitals, community and advocacy groups, the Governor, and special legislators. Even though the board's recommendation against closing the center was not accepted by the State, special consideration was given to the problems identified in the board's study (e.g., relocating fragile elderly patients) in the final decision regarding the facility. This action was a credit to the board's thorough and credible evaluation of the proposed closing of the facility.

Accessibility

The work done by the High Point (North Carolina) Mental Health Association to assess the need for expanded emergency services and later to monitor the delivery of those services is discussed by Barbara Geddie. The association's focus on accessibility of such services came at a critical time. Both private and public resources, including the National Institute of Mental Health, were aware of the deficiencies in emergency services. By interviewing magistrates, patients, and local hospital, police, and other officials, the monitoring team determined that services were responsive and effective during daytime hours, but that after office hours services could only be obtained 20 miles away. The mental health association board recommended an alternative plan for better coverage and supported the center's request for increased funding to provide that coverage.

28. Citizens Review the Needs of Special Populations

Lois Van Valkenburgh

Alexandria (VA) Community Mental Health Center

SUMMARY

The Alexandria Community Mental Health Center (ACMHC) has an 8-year reducing Federal grant, now part of a State block grant. The center is presently in its fourth year of the grant. In 1980, before preparing the second-year grant, the board determined that a needs assessment was necessary to give direction to programs at the center. The results of the needs assessment were included in the third-year grant application and implementation was reported in the fourth-year application.

TYPE OF ORGANIZATION

The governing board of the Alexandria Community Mental Health Center is composed of 15 community members balanced with respect to age, sex, economic level, and ethnic composition, as well as interest in mental health, mental retardation, and substance abuse.

EVALUATORS OR MONITORS

The study was conducted by the research and evaluation division of the center and the full membership of the governing board. Interviewing was done by the board's members: two lawyers (one retired), one college student, two housewives, eight persons working full-time in various jobs (none of which were in mental health), and one retired civil servant.

REASONS FOR THE EVALUATION OR MONITORING

The ACMHC governing board is responsible for establishing center policy and overseeing center programs and finances. The governing board

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continually monitors center programs. The needs assessment addressed certain areas that the center's board and staff identified as requiring further attention.

LEVEL OF PARTICIPATION

The board was involved in every aspect of the study. Members first met to discuss areas to be addressed in the study. A number of areas were discarded as not requiring community assessment; others were thought to be too limiting. The director felt that residences for the chronically mentally ill and the problem of youthful truancy in the schools were not being addressed by the center's staff and board and that these were areas of greatest concern to other public and private agencies in Alexandria. The board settled on four target areas: truant youth; outreach to blacks and other minorities, such as the increasingly large populations of Asian and Hispanic backgrounds in the city; additional outreach to the nonpoor elderly population; and supervised apartments or residences for the chronically mentally ill. The board assisted in designing a questionnaire. With the research and evaluation staff they determined that the interviews would be confined to "key informants." These would be community leaders, selected by board members, who dealt with the target populations in either a helping or monitoring manner. Board members conducted 90 percent of the interviews. Staff confined their interviews to colleagues within the city government and in helping agencies and prepared a final report for the board. Board and staff developed program recommendations together.

TARGET OF EVALUATION OR MONITORING

Alexandria is a community of about 104,000 persons, 22 percent of whom are black and approximately 3 percent Asian and Hispanic. Nearly 22 percent of the population is over 65 years of age and nearly 20 percent of the families have incomes of less than $20,000. Other mental health resources in the city include private practitioners, one hospital with an inpatient psychiatric unit, three or four small private agencies, and the city's health department. ACMHC provides the following services: outpatient, inpatient, partial hospitalization, 24-hour emergency, diagnostic and evaluation, and consultation and education.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The study addressed four specific areas of concern to the board and staff: (1) locating and treating truant youth; (2) outreach to minorities and refugee populations through community leaders; (3) community residences for the chronically mentally ill; and (4) consultation and education activities for nonpoor elderly persons.

TECHNIQUES USED

Based on their interests, board members elected to participate on one of four committees, each addressing one of the four areas of concern. A staff member was assigned to each committee. Other volunteers with special expertise were recruited by board members to assist in the interviewing. A single interview form was developed. On the advice of the board members, the instrument was modified slightly for each target group. The key informants, or community leaders, were selected by board members who were knowledgeable about the community. Key informants included clergy, school officials, and city employees. Fifty-three personal interviews were conducted, each lasting anywhere from ¾ to 3 hours in length. Orientation and training of board members was conducted by research and evaluation staff and the center director. Tools for the interview included copies of the center's annual report, the interview form, and the volunteer and client handbooks.

FINDINGS OF EVALUATION OR MONITORING

Board members felt that the interviews were useful in determining the key informants' perceptions of community needs and the level of satisfaction with the center. Generally speaking, the selected interviewees proved to be well-informed persons with knowledge of the needs in the targeted areas.

The study indicated that there were distinct needs within minority groups, particularly among the Indochinese and Hispanic populations. Community leaders and social workers need to develop techniques to help these populations learn about the services available to them.

Statistics were supplied by key informants indicating the number of chronically mentally ill persons needing residential services. Interviews were conducted to determine availability of housing in the city, and the type of housing required by chronically mentally ill individuals (e.g., supervised apartment, group home, etc.).

Those concerned with elderly persons emphasized the perceived stigma of attending a mental health center and the need for additional outreach services into the high-rise apartment and condominium areas of the nonpoor elderly. Teachers, school administrators, staff from the courts and social services, as well as private citizens, noted the lack of day treatment for truant youth and the need for close cooperation among the schools, courts, social services, and the center. Identified causes for truancy were: the home and parents, family conflict, broken homes, single-parent households and the like. Training in

coping skills and developmental processes, drug counseling, and the building of self-esteem and self-awareness were cited by informants as needs.

RECOMMENDATIONS

As a result of the needs assessment, board and staff set goals for the third year of the grant in all four areas. Recommendations included:

- Planning additional outreach activities for the elderly
- Development of consultation and education programs for bilingual community workers in order to reach minority populations
- Development of a strong cooperative relationship between junior and senior high schools and the center's youth day treatment program; and expansion of consultation and education activities to parent/adolescent relationships
- Development of supervised housing for chronically mentally ill with an emphasis on apartment living, since housing availability within the city is extremely tight

STEPS TO ENSURE IMPLEMENTATION

The board, through monthly meetings, continued to monitor the targets selected. In preparation of the fourth year of the grant, the board asked staff for reports on the success of their efforts in reaching the four populations.

EXTENT OF IMPLEMENTATION

The following changes were made:

- The director hired a transitional living coordinator to find apartments for the chronically mentally ill.
- An adolescent day treatment program was added to the center's partial hospitalization program.
- The consultation and education staff continued its outreach programs at senior centers and added nursing homes, retirement centers, and church groups.
- The consultation and education staff also offered its services to bilingual community workers and to agencies involved with Asian and Hispanic groups.

SPECIAL BARRIERS OR SUPPORTS

This study was a true cooperative effort between the board and center staff. The center director worked closely with the board chairman and was strongly supportive throughout the study. The major barriers were the 6-week limit on the needs assessment and time constraints on board members, most of whom held full-time jobs.

RESOURCES AND COSTS

Board members contributed nearly 100 hours for planning and interviews. The research and evaluation director and her assistant were assigned nearly full-time for analysis of the questionnaires. CMHC clerical staff assisted. The study was financed out of center funds.

ADDITIONAL COMMENTS

This 2-month activity served a number of purposes. It confirmed both board and staff's feelings about the needs of certain populations in Alexandria. It also confirmed their feelings about center goals for the next year and was a learning experience for board members. Their knowledge of center services and staff capabilities was vastly expanded and relationships between center staff and board were solidified.

29. Mental Health Advisory Board Evaluation of a County Mental Health Department

Ed Diksa

Sonoma County Mental Health Board

SUMMARY

Each county mental health advisory board (MHAB) in California is charged with providing citizen and community involvement into the county's mental health plan for the upcoming year. The board is also charged with approving the "process" by which said plan was adopted, i.e., ensuring that the plan was the result of careful reasoning after assessing county needs and acquiring and responding to information from all relevant sources.

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TYPE OF ORGANIZATION

The MHAB is a State-mandated body composed of 17 members appointed by the county supervisors. A majority of the total membership must represent the general public and a majority of these members must represent consumer interests (either recipients of services or members of clients' families). The remaining members must represent the various disciplines within the mental health field.

EVALUATORS OR MONITORS

Our board consisted of six professionals working in the private sector and/or teaching in mental health related disciplines; five members of the general public (housewives, students, business people); and four consumers (one present user of outpatient services, one past user of inpatient and outpatient services, and two parents of consumers).

REASONS FOR THE EVALUATION OR MONITORING

Our yearly evaluation is mandated by State law. In addition to monitoring the mental health department, the board also serves as a channel of communication between the community and the department. The particular problems addressed in the evaluation were poor staff morale and functioning due to long-standing dissatisfaction with the director and the need to review the handling of state mandated budget cuts.

LEVEL OF PARTICIPATION

Since the problems facing the department were very different from previous years, the board was forced to treat them in vastly different ways. To address the fiscal problems, weekly meetings were held with the administrators and program chiefs. This enabled board members to determine the magnitude and areas of cuts the department was planning. Community meetings were also held to raise relevant issues. Board members were then held to review the various ideas and data and to form a list of recommendations.

The problem with the department director presented a much thornier issue since board members did not feel it was their place to become involved in personnel matters. The only avenues of intervention open to the board were issues of morale and quality of service. Meetings were held with staff of all levels, i.e., clerical, clinical, program directors, and other administrators. Numerous phone calls from staff who were unable to attend the meetings were also received. Board members then met as a group to assemble the findings. Once members had arrived at their conclusions, they were in a quandary as to how to proceed. The decision was to take a low profile since the department's internal turmoil had already received considerable attention in the press. Members went privately to each county supervisor and apprised them of the board's findings, suggesting that something needed to be done quickly.

TARGET OF EVALUATION OR MONITORING

This study encompassed both the fiscal problems of the entire county mental health department, as well as issues concerning the department head. The name of the agency is the Sonoma County Mental Health Department. The county has a population of about 300,000. It is composed of several suburban cities as well as widely separated and isolated rural areas. The administrative structure of the department includes a director, an assistant director, and a number of program managers who are in charge of specific program components.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The issues investigated, were twofold: (1) the board's response to budget cuts and (2) its response to the sinking morale and quality of services due to friction between the staff and the director. The board's primary concern in both issues was the quality of service. The budget cuts proposed were 10-15 percent of total program funds. The board felt that with cuts this size the department might be forced to restructure itself, rather than simply pruning some of its branches.

With respect to the second issue, board members were interested in finding out about the modes of communication between the staff and the director, as well as the effect this relationship has had on the manner in which services were being delivered.

TECHNIQUES USED

Virtually the entire MHAB was involved in this task. However, a core of five or six members was much more intensely involved than the rest. Since the board's mandated task is to get information and ideas from the community, various community groups were contacted and the issues of the budget cuts were placed before them. These community groups were then asked to react. Board members also visited the various program elements to learn how staff felt the proposed cuts would affect them, and if they felt that there were ways to alleviate some of the impending stresses. Finally, meetings were held with department and county administrators to discuss the board's proposals. In dealing with the issue of morale, interviews were held with nearly all levels of department staff, as well as with other county departments that had working relationships with the mental health department.

FINDINGS OF EVALUATION OR MONITORING

The board's major findings concerning budget matters were:

1. Nearly all program elements were already "cut to the bone" from previous reductions;

2. Administration and inpatient services had been less affected by prior cuts than had other elements;

3. There was massive support for the continuance of outreach services in all outlying districts (both the department and county administration had proposed closing all outreach offices as a means of meeting necessary reductions);

4. Staff had minimal knowledge of the budget situation and this seemed to be increasing the amount of tension in an already bad situation.

Concerning staff problems with the director, the board's findings were:

1. Staff felt they received inadequate support and information from the administration;

2. Administration paid no attention to staff suggestions;

3. Staff felt that the situation had gone on past the point of possible reconciliation.

RECOMMENDATIONS

The following fiscal recommendations were presented to the mental health department and to the county board of supervisors:

1. Computerize fiscal services and enhance debt collection activities;

2. Develop computer system to handle client records while maintaining client privacy;

3. Contract with private labs for testing services;

4. Contract for clinical services in those instances where they could be done more efficiently while retaining the quality of services;

5. Reduce paperwork and streamline administrative procedures;

6. Initiate self-help and peer counseling groups to relieve strain on development staff;

7. Place greater emphasis on short-term therapy for outpatients;

8. Provide a community development team to organize local community support and resources in the event that future cuts might necessitate departmental withdrawal from the outlying communities.

Concerning the problem with the director, the board's findings were reported to the county supervisors. The only recommendation was that the situation needed to change in the very near future.

STEPS TO ENSURE IMPLEMENTATION

To achieve the recommendations concerning the budget, approval of the county plan was delayed for several months. Without this approval the department was in danger of losing all State funding. While the department did not implement all of the board's recommendations, members felt that the major concerns had been addressed.

The final decision about the director was left in the hands of the county supervisors since they were the only ones with the authority to take any action.

EXTENT OF IMPLEMENTATION

The board of supervisors reclassified the position of mental health director so that the director no longer needed to possess a medical degree. This was done under the guise of economy with the rationale being that a professional administrator's salary could be significantly less than that of an M.D. This avoided civil service wranglings and other political fallout that would have occurred had the director been removed in any other way.

Budget cuts were made with an eye towards community needs. The principal goal of maintaining needed outreach services was attained. Cuts came from all sectors of the program rather than from one program component. This left the county with a bare minimum of coverage in nearly all areas. It is the board's hope that further service cuts can be avoided if some of the board's longer range recommendations are put into effort.

SPECIAL BARRIERS OR SUPPORTS

The factors that made this project more difficult were:

- The need to assimilate countywide data
- Time constraints of board members and staff
- Information provided by the administration was constantly changing. As a result, the board had no firm figures to rely on.

The major supports were:

- A unified, dedicated board
- Support (if not always agreement) from line staff
- Community support for the programs
- Encouragement from several county supervisors
- Contact with the state MHAB project office (a State level office designed to assist local MHABs)

RESOURCES AND COSTS

Overall, a minimum estimate would be about 1,000 hours of volunteer time over a 3-month period. There are no paid staff attached to the board. The line staff met with board members either as part of their work or in their off hours. Board members are reimbursed for expenses upon submission of the proper forms (not all members chose to submit such forms).

ADDITIONAL COMMENTS

In general, board members were satisfied with the job they did, considering the complexities of the situation. However, members felt that it would have been of great help to have clarified the support system from the start, to have developed a well defined organizational plan, and to be clearer and more forceful about the need for reliable data (both programmatic and budgetary).

The process itself seemed workable and capable of fulfilling the needs for involving citizens in discussions and recommendations. However, the meetings could have been run in a more streamlined manner in order to achieve comparable results in a shorter period of time.

Finally, and most importantly, members found it difficult to keep a focus on the overriding issue of service quality when confronted by economic and personality issues. The constraints imposed by budget cuts threatened to change the focus to more practical matters and to suggest certain short-term solutions that could potentially weaken the long-term viability of humane and just service delivery. There seemed to be an administrative attitude that there is only room for ethical discussions in times of surplus. To argue for ethical, humane treatment of clients in times of economic crisis was an uphill battle that board members felt they had to undertake. It gave clarity to the goals and engendered in members a sense of power that was needed in order to confront the situation in which the board found itself.

30. Volunteers Monitor State Institutions Serving a Metropolitan Area

Jan Holcomb, Ann Nerad, and Karen Helfrich

Mental Health Association of Greater Chicago

SUMMARY

The Mental Health Association of Greater Chicago (MHAGC) site visitation committee was initiated in the fall of 1977. Since its inception, the purpose of the committee has been twofold: (1) to monitor inpatient care in the Region II Illinois Department of Mental Health and Developmental Disabilities (DMH/DD) facilities on an ongoing basis and (2) to provide current information for MHAGC public policy and advocacy activities. After each site visit, the findings and recommendations are written up and submitted to the facility superintendent, regional administrator, and DMH/DD director. Implementation of site visit results has included use of the media, lobbying, and testifying before the State legislature.

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TYPE OF ORGANIZATION

The MHAGC is the largest metropolitan chapter in a network of 850 mental health association chapters whose goals are to promote mental health, to prevent mental illness, and to improve care and treatment of the mentally disabled. Programs which achieve those goals include public education and information, public policy, advocacy, and patient services. The site visitation committee is one of several program committees appointed by the MHAGC board of directors.

EVALUATORS OR MONITORS

Site visitation volunteers have diverse backgrounds. One-half of the team members are homemakers with professional degrees in teaching, nursing (two in psychiatric care), social work, speech therapy, and sociology. Currently

employed volunteers include a public relations specialist, a commodities broker, an artist, and a travel agent.

REASONS FOR THE EVALUATION OR MONITORING

The site visitation committee was initiated for several reasons: (1) a MHAGC board member, who had served as an ombudsman in another State, believed that the monitoring function could be performed by trained volunteers; (2) the concept was in keeping with the purpose of the organization; and (3) although periodically surveyed by the Joint Commission on Accreditation of Hospitals and the Illinois Department of Public Health, no independent advocacy organization monitored care and treatment in DMH/DD facilities on a continual basis. Furthermore, two of the six DMH/DD facilities were under fire in the press for various violations.

LEVEL OF PARTICIPATION

Volunteers have been involved in *all* aspects of the site visitation program including the following: (1) negotiating the working agreement with DMH/DD that resulted in an open door policy for the committee in all facilities; (2) developing site observation forms, procedures for site visits, and report writing format; (3) developing guidelines for training and inservice; and (4) developing job descriptions for volunteers and volunteer/association agreements; and participating in followup with DMH/DD officials.

TARGET OF EVALUATION OR MONITORING

The focus of the monitoring activity has been the six State-operated adult inpatient facilities for the mentally ill serving the greater metropolitan area (DMH/DD Region II). This region alone generates 15,900 admissions per year to these State-operated facilities. Three of the region's facilities serving the mentally ill are designated for acute care. The mission of a fourth facility is research and training, and the two most outlying institutions serve as long-term care facilities, although both receive acute admissions from their immediate catchment areas.

After surveying the adult facilities for 3 years, the committee members were trained to survey the three children and adolescent centers. Two of these units are within hospitals for acute illnesses, while the third is a separate facility on the grounds of a hospital for acute illnesses.

Finally, the successes of the site visitation committee prompted the members to develop the program statewide. Recently, training was offered to volunteers representing three of the State's other regions. The goal is to have association volunteers, where chapters exist, monitor all DMH/DD-operated inpatient facilities.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Site visits are comprehensive and cover the following facility issues: (1) goals, policies, and procedures; (2) physical plant and housekeeping; (3) staffing--composition and attitudes; (4) intake, referral and discharge procedures; (5) intervention modalities (psychotherapeutic services, vocational, etc.); (6) group living; (7) residents' rights; (8) utilization of community resources; (9) dietary service; (10) laundry; and (11) education model (children and adolescents). Particular attention is paid to the following persons: (1) the sensory impaired; (2) those not guilty by reason of insanity; (3) the difficult to manage; and (4) children and adolescents.

TECHNIQUES USED

Volunteers use observation forms to record the information gathered from onsite facilities and unit visits. Information is obtained through personal observations and interviews with patients, staff, and administrators. The information, compiled in a narrative report with specific recommendations, is submitted to the facility administration for a response.

The observation format was developed by volunteers and MHAGC's program director and is revised as needed. Resources that were utilized and adapted for the committee's needs included: *Citizen Evaluation of Mental Health Services: An Action Approach to Accountability*, the National Mental Health Association's *Community Mental Health Center Visitation Handbook*, the observation format of the Joint Commission on the Accreditation of Hospitals, and professional sources.

FINDINGS OF EVALUATION OR MONITORING

In the past 5 years, the site visitation committee volunteers surveyed six facilities under the leadership of two State mental health department directors, three regional administrators, and several institutional superintendents. Visitation findings reflect significant variations in physical plant, numbers and quantity of staff, clinical commitment, and leadership. For example, the two oldest facilities--built in the late 1800s--present different physical plant problems from those facilities constructed in the 1960s. The team also found that staff with 20 to 25 years of service have different attitudes regarding patients' rights and treatment programs than staff who are recent graduates of social work, psychology and activity therapy programs. Moreover, a business manager with 20 years of public service has a different leadership style from a clinical psychologist with experience in direct care.

Even within facilities, volunteers reported significant variations. Committee members observing two units in the same facility having the identical physical layout, treating patients with parallel clinical and demographic profiles, and possessing the same staffing pattern, might find one unit clean and tidy, decorated with artwork and plants, and with current clinical documents and expectations clearly posted. The other unit might offer none of those characteristics. Perhaps the most unique contribution of the committee is systemwide observation over time.

RECOMMENDATIONS

A sample of the types of recommendations presented to the relevant facility/unit include the following:

- Facility-specific recommendations.--Patients' rights will be displayed clearly and permanently by the nursing station; bathrooms will have soap and toilet paper; the gymnasium will be available on a regular and predictable basis; restraints will be removed from individual beds when not being used; contact paper on bedroom windows should be used as an alternative to ripped and filthy drapes hanging by a couple of hooks.

- Intrafacility recommendations.--Units performing a good job in linking patients with community clinics should offer training to other units that are not assuring continuity of care; "successful" discharge staff should help "failing" discharge staff develop techniques and procedures to strengthen patient/community connections; units using a behavior modification orientation should clarify their "overt systems" guidelines to reward appropriate behaviors to be certain that patients understand exactly what they have to do for each reward, for example, earning a grounds pass.

STEPS TO ENSURE IMPLEMENTATION

The visitation reports are addressed to the facility superintendent with copies sent to appropriate regional and central office staff. Upon receiving the facility superintendent's response to the report, the team conducts a followup visit to determine whether or not recommendations have been carried out. These visits are goal specific and usually shorter in length. Reports from the followup visits may be in the form of a letter or short memo reporting the team's findings. Typically, some improvement is found on a followup visit in the areas for which the facility has resources.

Another step ensuring implementation is the monthly meeting of the site visitation committee chair, the children and adolescents subcommittee chair, and mental health association staff with the Region II administrative staff. This meeting addresses facility-specific as well as regionwide issues.

In addition, Mental Health Association of Greater Chicago (MHAGC) volunteers and program staff have worked diligently to establish a rapport with State legislators and their staff. For example, in the spring of 1982, House Republican staff contacted the MHAGC to assist them in developing the agenda for public hearings regarding the DMH/DD appropriations; in early winter 1983, the Illinois Commission on Mental Health and Developmental Disabilities did the same. Moreover, site visitation commitee members have offered testimony to legislative committees on public policy issues affecting the care of the mentally ill in Illinois. At the urging of the site visitation committee, the mental health association in Illinois worked through its lobbyist to introduce a bill recommending upgrading and/or closing of certain State facilities.

The committee also shares information with the Illinois Guardianship and Advocacy Commission and its human rights authorities (HRA's). These HRAs have investigative and subpoena powers but do not monitor inpatient care on a routine basis; thus, it is beneficial to both site visitation members and the HRAs to maintain close contact. The site visitation committee has provided training both for paid staff and volunteers of several of the HRAs in Illinois.

After 5 years of visitations, reports, recommendations, and followup, committee members were still frustrated that system changes had not been made at the executive and legislative levels. It seemed necessary to call public attention to these problems in order for the decisionmakers to address them. When reports from the *Chicago Sun-Times* requested a comment on one small recurrent problem, the committee suggested that they consider addressing the problems of the larger mental health system utilizing MHAGC's expertise. After a briefing session and an editorial decision to pursue problems in depth, site visitation volunteers and MHAGC's program director accompanied news reporters to each facility and provided contacts to them for other aspects of their proposed series.

EXTENT OF IMPLEMENTATION

At the facility level, the committee has found that the majority of the facility superintendents have attempted to correct identified deficiencies within existing fiscal limitations. For example, housekeeping practices have been improved in many instances; on most units, information orienting patients to time, date, rights, and activities are now more likely to be in place; access to activities and the addition of activity

personnel have increased; facility administrators have helped certain unit service supervisors manage their units more effectively; and patients in most units now have access to their bedrooms for rest periods (in the past bedrooms were locked in the morning and remained so until bedtime). The amount and quality of staff interaction and treatment services that patients receive are ongoing concerns for the committee and require constant monitoring.

The *Chicago Sun-Times* investigation, referred to earlier, resulted in a six-part series entitled "Breakdown: Mental Health in Crisis." The series accomplished its purpose in that either the Governor or his staff personally visited each Region II facility. The Governor also appointed a task force to address the issues outlined in the series and solicited the site visitation committee's ideas in the planning process. For example, the committee met with the Deputy Governor and presented three specific recommendations concerning system level reforms. All three recommendations were acted upon; the most significant action exempted DMD/DD from an across-the-board 4-percent reduction due to affect all code departments. Furthermore, the Deputy Governor invited the committee to review the 1982-83 budget prior to submitting it to the legislature. Finally, on the legislative front, the Mental Health Association of Greater Chicago introduced a bill which reflected the recommendations of the site visitation committee. The bill was passed in the Senate but failed in the House.

SPECIAL BARRIERS OR SUPPORTS

Although the site visitation committee has had a highly dedicated core of volunteers, normal attrition (i.e., moving away, employment, etc.) has limited expansion of its monitoring activities to include the private sector. In addition, though the professional volunteer group makes evening and weekend visits, this employed group is small and often without transportation; thus, nonweekday visits to the outlying facilities are almost impossible and visits to the closer facilities are not as frequent as they should be.

Another problem has been the amount of time required to compile the site visit report. Written observations must be collected usually from three to four volunteers who may be busy with other commitments; therefore, it is difficult for the team leader and the association to complete the report within the required time period. To resolve this problem, smaller teams have been designated to cover fewer units per visit.

Other barriers are unique to a large state bureaucracy including: the institutionalization of certain staff; an employee union that protects abusive or incompetent staff; and the "refer it for further study to a committee" approach to problemsolving and other issues. When necessary, the media has been used to publicize these problems and, therefore, to put pressure on elected officials.

Particular supports to this committee include the following: a program director who is knowledgeable in, and committed to, public policy and the volunteer-staffed site visitation program; a board of directors who support the purpose of the site visitation committee, i.e., to be the "eyes and ears" of the association; and the public and private sector's involvement in training committee members.

RESOURCES AND COSTS

Volunteers pay their own expenses (i.e., transportation, daycare, meals, etc.), and there are no recruitment costs since volunteers and staff recruit other potential members. (The Junior League of Chicago is a primary recruitment source.) In 1981, 10 volunteers donated 720 hours or 120 days to the site visitation program. This total includes only the actual visits and report preparation time--not time spent in meetings, lobbying, testifying, and traveling.

MHAGC staff is also provided to the site visitation program. Approximately 50 percent of two staff positions--the program director and the program secretary--are allocated to site visitation and public affairs. Other indirect costs that are covered by the association include phone, supplies, postage, and staff travel reimbursement.

ADDITIONAL COMMENTS

In addition to its achievements in the areas of care, treatment and human and civil rights of the institutionalized mentally disabled, the site visitation committee has greatly enhanced the image of the Mental Health Association of Greater Chicago as a public policy resource and advocate. In the spring of 1982, the site visitation program was recognized by the Volunteer Action Center of Comprehensive Community Services of Metropolitan Chicago for its innovative use of volunteers in accomplishing agency purpose. Furthermore, at the spring 1982 DMH/DD annual mental health luncheon, the site visitation committee received one of two awards selected by the director for unique and innovative programs benefiting the mentally ill. And finally, the site visitation committee has been recognized by the National Mental Health Association as an exemplary monitoring effort, and requests are received from MHAs across the United States that want to replicate the program.

The success of the program involves several key elements including trained and committed volunteers as well as the capacity for self-evaluation that leads to continued program improvement. The intent of the program was not to rely on sensationalism through the release of public reports but to effect change through

ongoing monitoring. Even in providing information to the media, the integrity of the site visitation program was maintained and the open door policy with the state DMH/DD was not jeopardized.

31. Mental Health Board Members Allocate Resources Using a Computerized Decision Tool

Jean A. Abruzzino and John D. Corrigan

Franklin County Mental Health Board

SUMMARY

Each year the planning committee of the Franklin County Mental Health Board undergoes an extensive evaluation process to assess need, to determine priorities for services and recipient groups, and to recommend allocations for the next fiscal year. Because of the complexity of multiple funding sources, as well as the multiple needs of individual agencies, planning committee members use a computerized decisionmaking tool when developing final recommendations for funding priorities.

TYPE OF ORGANIZATION

As prescribed by State law, the Franklin County Mental Health Board is composed of fifteen volunteers representing a variety of occupations and interests. Two-thirds of the members are appointed by the county commissioners, and one-third is appointed by the director of the Ohio Department of Mental Health. Duties of the board include planning, funding, evaluating, and overseeing the development and creation of mental health services located in the community. The board does not operate services directly but instead uses a purchase-of-service mechanism to contract with private, not-for-profit agencies.

EVALUATORS OR MONITORS

Many board responsibilities, including evaluation, fall under the purview of the planning committee. The committee is made up of seven board members, one representative of the chairpersons of Franklin County's seven catchment areas, and one representative of the seven catchment area executive directors. Members of the planning committee come from varied backgrounds including physical medicine, politics, labor management, higher education, and business. Professional board staff provide members with technical expertise and assistance.

For further information write Jean A. Abruzzino, Director of Planning, Franklin County Mental Health Board, 447 East Broad Street, Columbus, OH 43215, (614) 224-1057.

REASONS FOR THE EVALUATION OR MONITORING

Under Ohio law, the county mental health boards are responsible for community mental health planning. The planning process developed by the Franklin County board occurs annually, several months prior to the beginning of the next fiscal year. In the light of shifting needs and resources, objective, ongoing review of priorities and funding for services is an essential part of targeting services and maximizing dollars. Through this process, accountability to the community and to funding sources is maintained.

LEVEL OF PARTICIPATION

During the planning process for fiscal year 1982, committee members were actively involved in evaluating needs data, reviewing projections, and voting on systemwide priorities for services and specialized populations. Information and ideas from board staff members and the seven catchment areas were also utilized. The committee members took into consideration the services that were available outside the community mental health system, as well as agency funding from sources other than the mental health board, in an effort to coordinate a balanced mental health delivery system.

TARGET OF EVALUATION OR MONITORING

The committee is charged with planning mental health services on a countywide basis. Approximately 870,000 persons reside in Franklin County; as such, the mental health system is complex, consisting of seven catchment areas and 34 direct service providers. Committee members plan for a continuum of residential, day treatment, outpatient, consultation and education, and emergency services for all age groups. Programs can be either specific to catchment area or countywide. In addition to mental health services, committee members also plan for countywide drug abuse services. Planning is thus broadly based and targeted at many different program areas, agencies, and recipient groups. The following partial list of services illustrates the

diversity of programs that committee members must address: supervised apartment living; adult foster care; services for the severely emotionally disturbed child and adolescent; a halfway house for runaway youth; general counseling services; a battered women's shelter; and residential homes for aftercare and drug abuse clients.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The committee members, during the annual planning and evaluation process, consider revenue projections from all agencies, as well as an initial estimate of funds available from Federal, State and county sources. Projected services are looked at in relation to needs data, including past purchase-of-service, agency budgets, and census demographics. Priorities for mental health and drug abuse services are evaluated in terms of the function they are intended to serve (i.e., crisis stabilization, growth, sustenance), and the environment in which they are delivered (i.e., protective, supportive, natural). In addition, the committee must agree on the minimum resources to be provided to particular recipient groups (i.e., children, adolescent, adult, elderly, aftercare). Both long and shortrange planning are incorporated into this process. Consideration of shifting needs and revenues affect more immediate goals, while the availability of historical data allows committee members to evaluate progression toward long term goals.

TECHNIQUES USED

In order to evaluate resource allocation issues, the planning committee is assisted by a computer tool known as the Goal Programing Model (GPM). The GPM allows consideration of a variety of complex funding scenarios, permitting planners to evaluate the impact of priority decisions on all aspects of the system. Through a weighted voting procedure, initial priorities are determined by committee members and then entered into the computer. Based on these priorities, the GPM provides a "solution" showing the distribution of dollars that would occur across programs and recipients. Committee members then evaluate the solution, review priorities, and compute new solutions until satisfied with the distribution pattern. The following pieces of information are incorporated into the computer model:

Services.--In the GPM, services are divided initially into either mental health or drug abuse disabilities. For each type of disability, services are further defined by the functions (i.e., crisis stabilization, growth, sustenance, consultation, and education) specified in the balanced service system model adopted by the Joint Commission on Accreditation of Hospitals. Most service functions can be delivered in one of three service environments--protective (inpatient), supportive (the mental health system), and natural (the home, school, or place of work). When a service function is matched with a specific service environment, a cell is created. Within each cell, services are further specified in the GPM by five characteristics: (1) type of service (e.g., residential or day program), (2) required supplemental service (e.g., case management), (3) service delivery agency (e.g., one of 34 contract or subcontract agencies), (4) recipient (e.g., child, adult) and (5) recipient's catchment area of residence.

Need.--The GPM contains the previous year's service delivery level for all levels of each variable just described. Data from a countywide demographic projection of ideal service levels are also incorporated.

Finances.--The GPM has three pieces of financial information for services delivered by each agency: total revenues available, the sources of revenues (i.e., community mental health funds, Title XX, specific Federal funds), and the cost per unit of service. When several agencies offer the same service, the GPM selects the lower unit cost, thus encouraging efficient service delivery.

Priority and recipient group constraints.--Committee-determined priority weights and minimum funding levels for specialized populations are included in the model. Within the computer pogram, priority weights allow the value or importance of services to be reflected in their funding levels.

The Goal Programing Model (GPM) uses all of the above information to accomplish three criteria: (1) minimize unmet need based on priorities given to those needs, (2) accomplish criterion (1) in the most financially efficient manner possible, and (3) accomplish criteria (1) and (2) within the technical constraints required for a feasible allocation pattern. Thus, each time the computer buys a unit of service, it is looking at whether the service is needed, how important the service is, where the service can be purchased at the lowest cost, and whether it is feasible to buy it.

A set of reports is produced automatically each time a model is run on the computer. Each report has been developed to provide committee members with a different perspective on the distribution of funds according to a particular GPM solution. For example, table 1 shows the spread of total dollars and units across service function and environment. The effect on service distribution due to committee changes in priority weightings is best tracked with this report.

FINDINGS OF EVALUATION OR MONITORING

With the aid of a computerized model, the process of ranking by priority involved committee members in planning for expanding service needs during a time of shrinking revenues. Recognizing that resources could not meet all the mental health needs in the county, priorities were spread

across the system in such a way as to ensure that the greatest need was met at the lowest cost. After assigning weights to each mental health service, the services were ranked. Mental health priority rankings shifted somewhat from the previous year, but rankings for substance abuse services remained constant. For 1982, the three top-ranked mental health services included crisis stabilization in a supportive environment, growth in a supportive environment, and growth in a natural environment. The committee also identified as recipients three priority groups: children, adolescents and aftercare clients.

RECOMMENDATIONS

Funding for all agencies was recommended at 90 percent of 1981 mental health board levels, with the exception of the three recipient priority groups cited above. Funds beyond the 90 percent level were to be distributed among the priority areas in the following way: day treatment and outpatient services for children, 0-12 years; day treatment and outpatient services for adolescents, 13-17 years; and residential, day treatment, and outpatient services for aftercare clients, age 18 years and older.

STEPS TO ENSURE IMPLEMENTATION

Each year funding recommendations are presented at public hearings to allow agency and community feedback prior to submittal to the full board. Following board approval, the final package is routed to the finance committee to be used in writing individual agency contracts for purchase-of-service units. Priority recommendations for services are reflected in the contracts since they delineate the number of units of service to be purchased from each program area, as well as the unit cost at which the agency is to be reimbursed by the board. In addition, recommendations affect ongoing planning committee decisions regarding the development or termination of programs.

EXTENT OF IMPLEMENTATION

Due to funding reductions and uncertainties at the Federal and State levels this past year, recommendations for allocations beyond 90 percent of 1981 mental health board funds for children, adolescent, and aftercare clients could not be implemented. Although all services are currently funded at this 90-percent level, the priority weights and recommendations developed during this process continue to influence planning decisions.

SPECIAL BARRIERS OR SUPPORTS

The primary barrier to the 1982 planning process was the inability to project accurately what revenues the committee could use in its decisionmaking process. At the Federal level, the extent of proposed reductions in Title XX funding was unknown. In addition, the financial impact of moving from Federal categorical grants to State block grants was difficult to assess. At the State level, severe economic conditions and recurring fiscal shortfalls slowed the development of a State budget. A series of interim State budgets made planning a virtual impossibility. Throughout the current year, periodic reductions in the State mental health budget have necessitated conservative planning and funding.

The Goal Programing Model (GPM), however, serves as the greatest single source of technical assistance for committee members. In spite of its complex appearance, committee members have found it a useful and understandable tool for analyzing different funding scenarios and evaluating the impact of different decisions. The GPM has allowed board members greater control over the complex decisions involved in mental health planning. The actual reports produced by GPM "solutions" were developed with committee member input. These reports provide funding information on a variety of levels and are produced in formats designed to summarize data clearly. The GPM has added a degree of objectivity to what was previously a highly politicized decisionmaking process. The level of current planning effort would be impossible without this computer support.

RESOURCES AND COSTS

Consulting and computer support are provided through board-approved contracts with the Ohio State University. In 1981, contract costs amounted to approximately $38,000. This level of funding represents the investment in initial development. Future annual costs, however, will be lower, primarily covering upkeep and maintenance activities. The entire planning process for 1982 occurred over a 3-month period that began in April of 1981. Committee members and board staff met weekly throughout April and May. Public hearings were held in early June, and final recommendations were approved by the board two weeks later.

ADDITIONAL COMMENTS

The GPM is undergoing constant development. Board and contract staff have expanded the model's original capabilities and are now using the computer to create scenarios that can project the distribution of funds in the event of a sudden, systemwide financial disaster, and that can predict the need for additional levy monies. Report formats continue to be improved based on continuing updating by committee members. The Goal Programing Model (GPM) retains its ability to adapt to new planning techniques and needs--a

quality that is particularly important in a time of funding uncertainties. A decision support tool of this kind provides board members with the flexibility needed to plan effectively for the mental health needs of Franklin County residents.

Table 1

DISTRIBUTION OF FUNDS BY SERVICE FUNCTION AND ENVIRONMENT

Summary of Money Allocated by Service and Environment

Grand Total of Money Allocated: $20,600,316.77

		BSS Reports		
		Protective	Supportive	Natural
Crisis Stabilization	Units	5576	45532	3566
	Dollars	$254,049.00	$2,555,146.51	$148,132.00
Growth	Units	2168	288984	12221
	Dollars	$37,456.00	$12,701,837.85	$280,501.38
Sustenance	Units	489	38800	16815
	Dollars	25,711.00	$1,867,075.64	$259,534.00
Supplement	Units	2024	21781	7047
	Dollars	$93,220.00	$974,120.94	$253,607.48
Consultation and education	Units			30467
	Dollars			$1,449,925.00

32. Citizens' Group Responds to Regional Funding Needs

Frances P. Meehan

San Gabriel Valley Mental Health Services, Liaison Committee

SUMMARY

The San Gabriel Valley Mental Health Services Liaison Committee found a gross disparity in the level of State and county mental health funds allocated to the San Gabriel Valley as compared to other regions in Los Angeles County. Facts were assembled, graphed, and presented by a citizen group to the Los Angeles County Supervisor from this district. The result was an immediate and substantial increase in funding and a marked improvement in funding, manpower, and facilities since since action was taken in 1972.

For further information write Frances P. Meehan, Ph.D., 460 W. Walnut Avenue, Arcadia, California 91006, (213) 446-4062.

TYPE OF ORGANIZATION

The Mental Health Services Liaison Committee (subsequently known officially as Regional Committee Liaison Committee or RCLC) is composed of lay citizens who live in San Gabriel Valley and who are representative of the socio-economic, ethnic, and occupational demography of this area. The role of the committee is to advise the director of mental health services regarding the needs of the region and to educate organizations about the services available. The 24

members of the committee are appointed by the county director of mental health services on the advice of the regional director.

EVALUATORS OR MONITORS

The members of RCLC were educators, community leaders, and relatives of clients. In 1972, when these events took place, there were members of the League of Women Voters who had recently conducted a study of mental health services. The chairman of the RCLC, who had a degree in medical physiology, worked very closely with professional staff as well as committee members.

REASONS FOR THE EVALUATION OR MONITORING

The San Gabriel Valley became a region of Los Angeles County three years before the study took place in 1972. At that time, the region--which represents one-fifth of Los Angeles County--had a grossly inadequate level of funding, insufficient manpower, and only one facility to meet its needs. All fiscal accounting was done in the central office, but it was obvious that, year after year, the San Gabriel Valley received far less than its fair share. The RCLC participated each year in evaluating the needs of the region and assisting in development of the plan for mental health services prepared by the Los Angeles County Department of Mental Health for submission to the California State Department of Mental Hygiene.

LEVEL OF PARTICIPATION

The committee functioned as an independent entity--separate from the county advisory board or county department. The chairperson took the lead by studying the pertinent parts of the voluminous Los Angeles county budget. A clear presentation including percentages and bar graphs were then made to the liaison committee and to several community organizations.

TARGET OF EVALUATION OR MONITORING

In 1972, the San Gabriel Valley Mental Health Services Region was one of 12 in Los Angeles County, but it served by far the largest population, 1.2 million, or 17.6 percent of the total. The region covers a 772-square-mile area and the problem of transportation was (and is) great. Even though there were very few private mental health resources in the area, the county had set up only one clinic in the San Gabriel mental health service area. This was administered by a psychiatrist who reported to the psychiatric director of the Los Angeles County mental health department. He in turn reported to the Los Angeles County board of supervisors, composed of five men with absolute administrative and legislative power and no review of their actions.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The goal of the liaison committee was to alleviate the severe funding limitations that had resulted in a dearth of mental health manpower and facilities in the area--both public and privately contracted.

TECHNIQUES USED

The liaison committee had as part of its charge the review of the mental health needs of the citizens of the area and the establishment of priorities. When annual reports repeatedly resulted in little or no improvement in funding for needed services, it was obvious there was a maldistribution of funds in the county for professional personnel and facilities. To validate this perception, a copy of the pertinent sections of the Los Angeles County budget was obtained and reviewed. This material was then presented to citizen groups in a clarified form.

FINDINGS OF EVALUATION OR MONITORING

State mental health funds allocated by region within Los Angeles County in the 1972-73 budget showed that the San Gabriel Valley mental health service area received 6.1 percent of the total for 17.6 percent of the population, or the equivalent of $1.00 per capita as compared with $7.30 per capita in another region. The same budget showed that the area received 1.1 percent of county project priorities, and 4.5 percent of the contract allocations. The total per capita allowance (including hospitalization costs, contract costs, and jointly operated costs) for the San Gabriel Valley was $5.34 compared to a county average of $8.56, and a high of $18.78 in another region.

With respect to service need, the evaluation and research division of the Los Angeles County department of mental health ranked San Gabriel as number one on their need index. Using 15 variables, they reported a need of 15.31 percent. This meant that of the $60,000,000 projected for the county, the fair share for this region, would have been $9,186,000 instead of the $6,613,000 allocated.

Needs identified by the RCLC in a cooperative study with the staff were: (1) four additional satellites or clinics, (2) personnel to replace those lost in the "freeze," (3) personnel to staff additional clinics, (4) contract services, (5) crisis homes, and (6) children's services. In short, all the services for all ages were inadequate.

RECOMMENDATIONS

A report on these funding issues was made to

the county supervisor representing the San Gabriel Valley. The specific request was for an additional $2,500,000 in order to secure a fair share of the budget and to fund some of the identified needs for the region. Previous recommendations made to the director of mental health services for Los Angeles County had fallen on deaf ears.

STEPS TO ENSURE IMPLEMENTATION

Brief talks using charts and graphs were made to members of the liaison committee, the Los Angeles County mental health advisory board, American Association of University Women, League of Women Voters, Arcadia Coordinating Council, the Regional Planning Council of United Way, service clubs, and others.

Since requests to the director of mental health services for the county had gone unheeded, an appeal had to be made to the Los Angeles County Supervisor from the San Gabriel area. Because county supervisors are very powerful by virtue of their control over a huge budget and range of services, it was essential to make the strongest possible case. Twelve community leaders representing some of the above groups accompanied the chairperson of the committee to plead with the supervisor for a more nearly equitable division of State and county mental health funds.

Following the oral presentation, copies of a fact sheet, graphs, and tables comparing the 12 mental health regions with regard to population, area, State funds, per capita allocations, outpatient units of service, and cost per patient were presented to the supervisor.

EXTENT OF IMPLEMENTATION

The following week, the supervisor arranged for an additional $1,271,397 from recently released surplus State funds for mental health programs in the San Gabriel Valley. Because the county department of mental health and the board of supervisors do not take funding from one region to give to another, it would be achieved by allocating more "new money" to the neediest areas. It is important to note that the administration, organization, accounting procedures, and State plan requirements have all changed markedly in the last ten years.

SPECIAL BARRIERS OR SUPPORTS

The central accounting office of the county department of mental health did not make fiscal data available even to the professional staff, and certainly not to citizen groups.

Positive factors included the existence of a group of dedicated citizens who would, for the most part, be classified as "housewives" in 1972. They had the time, interest, and persistence. Finally, the process was enhanced by the concise presentation to a receptive supervisor of incontrovertible facts in graphic form.

RESOURCES AND COSTS

There were no paid staff and no monetary resources. After 10 years it would be difficult to estimate the many hours of volunteer time given by the citizens involved.

ADDITIONAL COMMENTS

This is an example of remarkable "beginner's luck" in having an impact on the political process. Advice to others includes the following:

- Present facts in clear, concise manner with visual materials.
- Leave copies with officials and with the press, if appropriate.
- Have a small group of respected advocates.
- Arrange a planned presentation for one or two speakers.
- Be courteous and positive.
- Send an immediate followup letter.

A lasting friendship and alliance with this supervisor was started at the above reported meeting. The chairperson has since been asked to serve on a number of blueribbon committees for health affairs and has served for two terms on the Los Angeles County mental health advisory board, two years as chairperson. Continued and remarkable improvement has been made in mental health services for the San Gabriel Valley.

33. A Community Service Board of Evaluation of Service Delivery

Barbara Todd

Fairfax-Falls Church Community Services Board

SUMMARY

The Fairfax-Falls Church community services board provides a comprehensive array of mental health, mental retardation and substance abuse services. Community service boards in Virginia are the agencies designed as responsible for administering the expenditure of public funds and overseeing the programmatic and administrative operation of these agencies. Members are appointed by the governing bodies of the communities served by each board.

As Federal funding for mental health services declined, it became apparent that modifications to the mental health system would be required. With this in mind, the mental health committee of the Fairfax-Falls Church Community Services Board created a consolidation task force (CTF) to explore the possibility that some form of systemwide consolidation could effect sufficient cost reduction to assure the maintenance of the current level of mental health services without adversely affecting service quality.

TYPE OF ORGANIZATION

Membership on the CTF included three members of the community services board. In addition, the citizen boards of all mental health agencies were invited to appoint two board members to the CTF. One member of the board of Alternative House (a residential crisis intervention program for adolescents), one citizen representative from alcohol programs and one person representing mental retardation programs were also appointed. All of these members were volunteers from citizen boards.

Nine staff members were assigned on a part-time basis to assist the CTF. The staff arranged visits to programs, collected and analyzed data, and shared their professional points of view but were not involved in the decisionmaking process.

The CTF organized itself into six committees representing functional service delivery needs that cut across the three disability areas of mental health, mental retardation, and substance abuse. The committees were: (1) outpatient/after care; (2) partial hospitalization/day treatment/vocational; (3) inpatient/residential; (4) emergency services/recreation; (5) community services; and (6) consultation and education/evaluation/transportation.

For further information write Barbara Todd, Vice Chairman, Fairfax-Falls Church Community Services Board, 301 Maple Avenue West, 3rd Floor, Vienna, VA 22180; or Barbara Todd, 312 Van Buren St., Falls Church, VA 22046, (home) (703) 532-8191; or Joan Durman, Director, Evaluation and Quality Assurance, 301 Maple Avenue West, 3rd Floor, Vienna, VA 22180, (703) 281-6420.

EVALUATORS OR MONITORS

All CTF members were selected because of their involvement as volunteer members of citizen advisory or governing boards. Every effort was made to include representatives from all disability areas and from a wide range of programs.

REASONS FOR THE EVALUATION OR MONITORING

The CTF was formed to review the entire service delivery system and all levels of administration of the Fairfax-Falls Church community services board and to make recommendations regarding improved service delivery, filling service gaps, and especially the operation of the system in a more cost-effective manner. Faced with the prospect of major budgetary restrictions, particularly those involving the stepdown of Federal funding in the mental health centers, it was necessary to explore all possible methods for reducing operational expenses.

LEVEL OF PARTICIPATION

The members of the CTF were directly involved in the following steps: establishing the direction and depth of the investigation, reviewing the programs and facilities, questioning the staff, requesting data or data analyses, soliciting information and ideas from staff and community, evaluating the information, developing recommendations, and writing the final report.

TARGET OF EVALUATION OR MONITORING

This investigation addressed the administrative and service delivery organization of the mental health, mental retardation, and substance abuse

programs sponsored by the Fairfax-Falls Church community services board. This community service board serves an area with a population of 625,800 persons. Federal, State, and local governments share in funding these programs. Some programs are operated directly by the community services board. Other services are purchased from private nonprofit organizations.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The main thrust of this undertaking was to determine whether one or more alternative structures could be developed that could operate more effectively and economically while preserving the level and quality of service. Additional concerns included the potential for improvement in quality and convenience of services and the elimination of any identified gaps in service.

TECHNIQUES USED

Each CTF committee visited all programs that provided services in the area of the committee's concern. Staff explained the service needs of the clients, the program staffing, administration, records, interrelationships with other programs and agencies, problems, and gaps. Reports describing the operation of the agency and its programs were made available to the committee. On the basis of the site visits and material reviewed, the six committees discussed and evaluated their findings and each developed a report to present to the entire CTF. In addition, 44 presentations by program staff were given to the CTF during three evenings of hearings.

FINDINGS OF EVALUATION OR MONITORING

The CTF was in agreement that although most clients in the system were provided with appropriate, high-quality service, several classifications of clients were being either poorly served or not served at all. These included clients who:

- Needed a variety of services within a disability area
- Needed services in more than one disability area
- Needed services from other social services agencies
- Were geographically or socially isolated

It was also the opinion of the CTF that the following conditions were detrimental to the development of a unified, effective, economical, administrative system:

- The organization of service delivery differed among the three mental health centers.
- There was no uniformity in administrative procedures such as billing, clinical records, purchasing, and personnel policies.
- There was duplication of effort in areas such as training, public relations, and evaluation.
- There were barriers to communication and cooperation among agencies.
- There was a need to strengthen systemwide planning and coordination.

The CTF estimated that, in addition to improved services to clients, the recommended restructuring of the system would result in a savings of approximately $1 million over a 5-year period and would offset the effect of the Federal grant stepdown until fiscal year 1986.

RECOMMENDATIONS

In regard to the organization of service delivery units, the CTF recommended the development of a comprehensive community services system that would include:

- Integrating mental health, mental retardation and substance abuse capabilities at intake
- Converting the mental health centers to community service centers more tightly networked with mental retardation and substance abuse delivery units
- Highlighting the case management function
- Establishing appropriate policies to ensure administrative commitment to service integration
- Assuring that advocates of mental retardation and substance abuse services are represented on the center governing boards

Recommendations to strengthen lateral cooperation of service delivery included:

- Organizing each service center along common lines internally: youth and family services, adult services, community care programs, emergency services, and consultation and education
- Providing systemwide client guidance at intake

- Sharing certain areawide specialized functions
- Applying uniform personnel standards and pay policies
- Developing uniform systemwide standards, forms, and procedures

Service improvement and operational economy should result from selectively decentralizing some services and centralizing others:

- Outpatient and "walk-in" counseling should be geographically decentralized to underserved populations in certain identified expanding areas.
- There should be centrally administered systemwide planning, coordination, and resources for certain professional support functions: evaluation, quality assurance, training, consultation and education, and client index.
- There should also be centralized planning, coordination, and resources for certain administrative functions: budget, transportation, personnel, purchasing, property management, public information, grants, and regulatory coordination.
- Certain specialized services should be centralized at a single appropriate service delivery site.
- When feasible, services should be colocated with other related human services.

The structure of the community services board administration should be steamlined with clearly defined lines of authority to service delivery units by:

- Having the directors of the community service centers report directly to the executive director of the community services board
- Providing coordination for contract agencies and for areawide programs in a division of special programs
- Maintaining a high-level focus on substance abuse and mental retardation through appropriate administrative authority
- Aggregating support resources for delivery units and for the executive director in two divisions: professional support functions and administrative support functions

On issues where the CTF was in strong agreement, a single recommendation was presented. When the CTF was divided, the alternatives were offered in the report.

STEPS TO ENSURE IMPLEMENTATION

The 62-page final report of the CTF was published and distributed to all members of the community services board, the directors and boards of all affected agencies, interested client support organizations, and the governing bodies of the jurisdictions served. The report was also made available to all other interested persons. In order to facilitate the implementation of the recommendations, the CTF advised that a public hearing be held, that an implementation advisory council be established, and that an implementation timetable be developed. It was also recommended that wherever possible implementation be as prompt as possible in those areas where there appears to be strong agreement.

The authority of the CTF was limited to undertaking an extensive study of the entire service delivery system and to developing recommendations for appropriate changes. The authority to effect any of the recommended changes rests with the community services board in those areas where policy changes are involved and with the executive director and his staff for matters involving implementation of policy.

EXTENT OF IMPLEMENTATION

Although this report was submitted in December 1980, no formal action has yet been taken (as of July 1982) to approve the implementation of any of the 33 recommendations. A number of situations have contributed to this neglect:

- At the time the report was presented, the community services board was functioning under an acting director and it was the sense of the board that implementation would only succeed under strong and enthusiastic encouragement from a permanent executive director.
- Specific changes in operating procedures were being strongly encouraged by the county management (the fiscal agent for the community services board). This absorbed an inordinate amount of staff time which otherwise would have been devoted to implementation of CTF recommendations.
- Many of the cost savings to be derived from the recommended changes in administrative services depended on the installation of an automated management information system for which specific recommendations are only now being completed.
- The mental retardation support community is strongly opposed to the concept of an

integrated service system, mainly out of fear of losing the "visibility" it has worked hard and long to establish.

- Changes at the State level indicate that funding will continue to be distributed according to disability area--an obstacle to developing an integrated system.

- Federal block funding of mental health center grants to the States has eliminated the requirements for a governing board for each mental health center, thus making it impossible to develop internally a strong, unified mental health system.

Nevertheless, the CTF report has served as a set of guidelines for many changes that either have been or are about to be made in the service system. In the past year, the trend has been toward the development of a unified system of mental health, mental retardation, and substance abuse services with stronger ties to other human services.

Greater concern is being shown for clients with special or multiple service needs and new procedures and service techniques are being developed for them. Case management is being extended to mentally ill and substance abusing clients who have been unserved or poorly served in the past. At the county adult detention center (i.e., local jail) services in all disability areas have been improved.

At the three mental health centers, alcoholism services are available and are being coordinated with mental health services. Progress is being made toward providing appropriate mental health services to mentally retarded clients. Contract agencies that originally provided vocational services to mentally retarded clients now have developed programs for the mentally ill.

In the administrative structure of the community services board, the establishment of the position of assistant director for services should ensure a unified approach and closer cooperation among all disability areas. All case management is now under a single director. The incorporation of the management of all residential program is currently in the planning stage.

There has been an appreciable reduction in administrative personnel, especially in the mental health centers. Some of this has been the result of combining small agencies under a single management or consolidating geographic locations of a single program. More progress in this area will be made when the management information system is in place.

Considering the fact that the community services board has had to respond to a change in executive director and strong directives for changes from local, State and Federal funding sources, it would seem as though a reasonable number of the CTF's recommendations have been implemented. In a more stable situation, a formal approach to the implementation process might have been preferable.

SPECIAL BARRIERS OR SUPPORTS

The time available is always a barrier in undertaking any study because the need for the results is urgent before the task is initiated. Other than that, there were no problems. The group was enthusiastic and hard working. Everyone was willing to devote the time necessary to complete the job. The staff was dedicated and supportive. All the agencies were cooperative.

RESOURCES AND COSTS

As closely as it is possible to estimate the time and effort expended in the project, the 15 citizen volunteers devoted approximately 4,000 hours to this effort and the 9 staff members spent about 3,000 hours in organizational and support activities. Each citizen member drove approximately 400 miles to attend an average of 25 meetings. On the basis of 20¢ per mile, this represents a contribution of some $1,000 in the interest of completing this task.

ADDITIONAL COMMENTS

This was a long, laborious endeavor. Time was needed to establish mutual trust and willingness to negotiate differences. It required a commitment to the concept that this was a necessary and worthwhile activity that would benefit all clients and help all agencies. It was an appropriate and effective approach to a complex and difficult problem. This project could not have succeeded without the enthusiastic support of the staff.

34. A Board of Visitors Monitors Client Rights Issues

Kelly Moorse

Montana Mental Disabilities Board of Visitors

SUMMARY

The Mental Disabilities Board of Visitors conducts annual reviews of Montana's community mental health centers, the State's three institutions for the mentally ill, and its two institutions for the developmentally disabled. As part of each review, the board examines patient care and treatment, medication, recordkeeping, and consumer issues, i.e., client rights, grievances, etc. After each site visit, a report of the board's findings is sent to each facility, to the Governor, and to the director of the department of institutions. In addition, board members together with staff respond to individual grievances regarding violation of rights, patient treatment, and other concerns.

TYPE OF ORGANIZATION

The Mental Disabilities Board of Visitors, established by the Montana Legislature in 1975, is charged by State law with reviewing patient care and treatment at Montana's community mental health centers, as well as its institutions for the mentally ill and the developmentally disabled. The board is administratively attached to the Governor's office and, therefore, is independent of any facility that it investigates.

The board consists of five members who are appointed by the Governor. The board's role is to monitor all aspects of patient care and treatment, as outlined in the State's two principal statutes governing the mental disabilities system: The Mental Commitment and Treatment Act and The Developmental Disabilities Act.

EVALUATORS OR MONITORS

Of the five board members, two are consumers who represent the interests of the mentally ill and the developmentally disabled and three are professionals: a clinical psychologist, a registered nurse, and a lawyer. Consultants in pharmacy, medicine, psychiatry, gerentology, and special education also are available to the board on a contractual basis.

For further information write Kelly Moorse, Office of the Governor, Mental Disabilities Bd. of Visitors, Capitol Station, Helena, MT 59620, (406) 444-4765.

REASONS FOR THE EVALUATION OR MONITORING

Montana law requires that each mental disabilities facility be visited at least annually. As an independent board of inquiry, the board of visitors is mandated to make annual site visits to those facilities within its purview. In addition, the board and its staff member must respond to individual grievances.

LEVEL OF PARTICIPATION

Board members are involved in every aspect of the facility reviews, including onsite visits to each facility. The board conducts an average of 10 site visits per year, spending 2 to 3 days at each site together with the board's staff member and contracted consultants. As part of the site visits, board members review various treatment and medication plans, inspect the residential and treatment areas, and assist individual clients who may have grievances. After each site visit, the findings of the board members and consultants are submitted to the staff member who will collate the information into a report. In addition to the scheduled site visits, board members respond to hundreds of individual requests by patients, their families, and the legal system to review and investigate, among other things, care and treatment issues.

TARGET OF EVALUATION OR MONITORING

The board of visitors evaluates the 5 regional mental health centers, 1 or 2 of the satellite mental health centers that are located within a region (the board's budget does not permit review of all 35 satellite centers within the State) and the 5 State institutions. Three of the five institutions are mental health facilities: Warm Springs State Hospital, the largest state facility; Galen's State Hospital; and the Center for the Aged. The remaining two facilities serve the developmentally disabled: Boulder River School and Hospital and Eastmont Human Services Center.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

During their site visits, board members conduct

the following activities: (1) ensure that treatment plans exist and are being implemented and modified as needed for each patient; (2) ensure that medication reviews are conducted and that no medication is given as punishment or for staff convenience; (3) review the use of all restraints, isolation and other extraordinary measures; (4) inspect the residential and treatment areas, recreational and dining facilities to ensure that they offer a therapeutic milieu; (5) review admissions and retention of patients to ensure that their legal rights have not been violated and that proper commitment procedures have been followed; and (6) assist patients in resolving any grievance regarding their commitment, alleged violation of rights or maltreatment at the facility. Other general concerns include record-keeping and staffing as they relate to overall patient care.

A primary focus of the board of visitors is responding to individual grievances. Some examples of individual grievances that have been investigated by the board include the following:

- A young woman at Warm Springs State Hospital was denied visitation, phone privileges, and home visits. Her family contacted the board of visitors, requesting that these rights be reinstated.

- A teacher from the public school system referred a young developmentally disabled person to the board of visitors who was institutionalized at a mental health facility and wanted to be released.

- A mental health center client contacted the board of visitors regarding a treatment plan that recommended inpatient thereapy at the state mental institution instead of outpatient services. An involuntary commitment hearing was requested by the mental health center at which time the board became involved.

TECHNIQUES USED

The board uses several techniques to assess patient care and treatment during a site visit: (1) interviewing patients and clinical and administrative staff; (2) observing patients and staff; (3) and conducting a random record review. The checklists that are used for the random file review are based on the standards established by Montana law (the medication checklist was developed for the board by a consultant). For the interviews and observations, an onsite review form is used that focuses on four major sections: (1) maintenance of records, (2) program and treatment plans, (3) training for resident case workers, and (4) treatment of residents, i.e., rights, abuse issues, etc.

In order to respond to individual grievances, the board has established certain procedures to follow in those cases. Board members and the staff person respond immediately to the grievance and collect any relevant information regarding the complaint including existing documentation, previous resolutions (if any), and possible alternatives that are acceptable to the client. The information is then analyzed and, if necessary, additional data are collected from other residents, facility staff or legal personnel. All of these resources are reviewed and possible solutions and alternatives are then discussed with the client. At that time, board members may advocate for certain changes on the unit where the client resides, request policy changes for the entire facility, request legal assistance, or work to change clinical and administrative staff attitudes.

FINDINGS OF EVALUATION OR MONITORING

Each site visit conducted by board members results in a list of facility accomplishments and deficiencies. Findings in each key issue area described earlier differ for each facility visited. With respect to client rights issues, the 1981 board of visitors review of Warm Springs State Hospital expressed the following concerns: (1) a copy of a patient's rights was not promptly given to each person upon admission--in some cases it was 8 to 15 days before the patient received a copy; (2) the rights of patients were not always posted in each ward--a direct violation of State statute; (3) procedures needed to be developed to reinforce the importance of a patient's rights throughout a person's stay in the facility; and (4) inservice training for staff regarding patients' rights, including the right to refuse treatment, needed to be implemented.

Specific findings also emanate from the board's investigation and evaluation of individual grievances. For example, after investigating the denial of visitation and other privileges to a Warm Springs patient, the board found that there were written orders restricting phone calls, visitors, and home visits--such orders are required by law if any rights are restricted. In another situation concerning the institutionalization of a young developmentally disabled person who wanted to be released, the board met with the individual, completed the investigation, and determined that the individual was not seriously mentally ill as defined by the law (the staff of the facility concurred with the findings). Lastly, for the client who was requesting outpatient as opposed to inpatient services, the board met again with the client and her court-appointed attorney to discuss the impending court proceedings and alternatives available to the client.

RECOMMENDATIONS

Recommendations vary according to the deficiencies listed in each site visit report. With

respect to the findings of the board in its 1981 report to Warm Springs State Hospital, the board recommended that the facility post copies of patients' rights in each ward and provide them with a copy of their rights whenever necessary.

Board members also make specific recommendations concerning individual grievance complaints. For example, for the young developmentally disabled individual who was inappropriately institutionalized in a mental health facility, the board recommended that the individual be referred to the prerelease unit, that the necessary paperwork be filed to obtain supplemental income, and that a group home placement be sought for this individual.

STEPS TO ENSURE IMPLEMENTATION

Each site visit report is sent to the reviewed facility within 60 days of the review; the facility then has 30 days to comment on the findings and recommendations. At that point, the final report is sent to the Governor's office and to the director of the department of institutions. The board's staff member has overall responsibility for following up on any deficiency that is related to patient care. Monthly updates and changes in the reports are reported to the board members. Other deficiencies may be followed up with subsequent site visits by the board. In the event of a serious deficiency, the board members and staff meet with the director of the department of institutions or the Governor's staff to explore possible solutions. The board's findings are also highlighted in the media.

With respect to the specific patient rights deficiencies discovered at Warm Springs, the board of visitors assumed the responsibility of refining and updating the existing procedures for informing patients of their rights. In addition, the board monitors the implementation of its recommendations regarding individual client grievances.

EXTENT OF IMPLEMENTATION

The facilities all respond differently to the board's findings. Some facilities are very resistant to change, while others use the reports to correct the noted deficiencies. In addition, many of the recommendations that are directed at removing deficiencies are contingent upon the appropriation of additional funds from the State legislature. In some instances, the facilities use the board's reports in preparing their requests for funding from the legislature.

With respect to the board's recommendations on client rights issues, four of the five mental health centers have implemented this policy within their regions. In addition, the board has sent a questionnaire to each State's protection and advocacy office in order to collect information on how States summarize patient rights; who informs clients of their rights; what resources are used in explaining rights to the developmentally disabled, the hearing or sight impaired; and if inservice training is provided, what models are used.

Board members have been able to implement several of their recommendations regarding individual grievances. For example, two of the three recommendations concerning the inappropriately institutionalized developmentally disabled individual have been implemented; however, the most critical recommendation, i.e., the group home placement, has been delayed because of a lack of community placements. The board, however, was successful in reinstating phone calls, visitors, and home visits for the client who had these rights restricted.

SPECIAL BARRIERS OR SUPPORTS

The major barriers to the board of visitors are limited resources and staff to assist board members in carrying out their mandated responsibilities.

RESOURCES AND COSTS

Each board member receives a nominal fee ($25) for each day of a site visit and funds to cover lodging, meals and travel expenses. Consultants are paid an honorarium ($100) plus expenses. In addition, the board employs one full-time staff member at $19,000 a year plus benefits to collate the board's information and to followup on individual problems and complaints throughout the State.

ADDITIONAL COMMENTS

The board of visitors is a legislatively mandated board of inquiry; however, its funding must be approved by the Montana Legislature every two years. Without this basic source of support, it would be difficult for board members to conduct site visits in all State facilities.

35. Consumers Evaluate Their Needs and Agency Programs

Joyce G. Smith

Hill House Mental Health Rehabilitation and Research, Inc., Cleveland, Ohio

SUMMARY

Since 1977, adult mental health consumers representing Hill House, a psychosocial rehabilitation agency, have functioned as client advocates and designed several instruments for assessing client needs and evaluating client programs in three of the agency's programs: the social program, the vocational program, and the transitional housing program. Members of the Client-Oriented Program Evaluation (COPE) group submit the results of the surveys to the agency's staff and board of trustees in order to make services, programs, policies, and procedures more responsive to client requirements. Some of the survey results and excerpts from the survey instruments have been disseminated to clients and professionals in the mental health field through public forums and professional publications.

TYPE OF ORGANIZATION

The Client-Oriented Program Evaluation (COPE) group consists of 15 volunteer clients or former clients of Hill House who meet weekly to discuss and design evaluation instruments. COPE works in conjunction with the agency's research director under a grant from the Ohio Department of Mental Health. COPE is an autonomous group within Hill House that is providing evaluative information to the staff and board of trustees in order to assure that policies, procedures, and services meet client needs.

EVALUATORS OR MONITORS

All of COPE's efforts are accomplished by its consumer members who volunteer to participate in evaluation activities; assistance is also provided by the Hill House research department. COPE members represent a cross section of consumers in terms of age, level of education, diagnosis, and socioeconomic background.

REASONS FOR THE EVALUATION OR MONITORING

In 1977, both the agency's research director and consumer members believed that clients should become involved in evaluating the efficacy of mental health services offered to them. Moreover, it was felt that clients would respond more affirmatively to an instrument developed by fellow clients who shared their experiences and respected their needs. As a result, COPE was formed to create a client-developed measured (CDM) of client progress to replace a behaviorally oriented measure (CDM was applied to all clients of Hill House). With the completion of this task and the prospect of continued funding, COPE decided to extend its evaluation activities to create a needs assessment questionnaire and several instruments to evaluate each of the agency's three components. The fundamental question underlying the involvement of clients in a needs assessment and program evaluation was whether clients, as unsophisticated researchers, could clearly determine client progress and client satisfaction with agency services and make realistic recommendations for changes in the agency.

LEVEL OF PARTICIPATION

COPE members have been involved in every stage of the evaluation project undertaken at Hill House. Beginning with the creation of the client-developed measure (CDM), clients wrote, edited, and revised the questions that became the final version. Client evaluators also studied the pretest results and were able to tailor the lengthy pretest version of the CDM down to its current size.

COPE members have worked closely with the agency's research staff, client coordinators, and other agency professionals in developing the evaluation program at Hill House. As COPE's involvement in evaluation expanded and progressed through various stages, the number of agency clients represented in the process also grew. The initial success of COPE's involvement in the CDM prompted the group to approach other evaluation topics, using the feelings of clients as the foundation for further research.

TARGET OF EVALUATION OR MONITORING

The COPE group has focused its efforts on assessing client needs and evaluating client programs provided by Hill House Mental Health Rehabilitation and Research. Hill House is located in the heart of the educational, cultural, and social service area on the east side of Cleveland (University Circle); it also operates a branch on

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the west side of the city. For over 20 years, the agency has served former patients from Cleveland's public and private mental health hospitals as well as persons with mental or emotional problems who have never been hospitalized. The program is administered by an executive director and governed by a 30-member board of trustees, three of whom are consumers or former client members of the agency.

A total of 33 staff, 19 of whom are professionals, work with approximately 592 clients per year. The principal component of Hill House is its social rehabilitation program. This program consists of group sessions led by social workers, and sometimes by clients, to explore subjects proposed by clients and staff. These sessions are supplemented by individual client-worker contacts and by client-initiated social activities, such as meeting informally over lunch in the agency's dining facility. Two other Hill House programs offer services to clients: (1) the vocational program serves 200 clients a year and provides training in clerical, food service, maintenance skills, and in job-seeking skills; and (2) the cooperative transitional housing program serves 24 clients a year.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The first research focus undertaken by COPE members was to design a self-assessment instrument that totally reflected the client's perspective on mental health and treatment progress. In developing CDM, COPE members discovered that while the clinician's focus was primarily on behavior as an indicator of improvement or deterioration, clients responded much more readily and positively to an orientation around feelings and needs. As a result of its success with the CDM, COPE decided to apply the "feelings" orientation to the other Hill House program, again, using clients as respondents. In addition, COPE's funding source requested that it develop a needs assessment instrument for Hill House clients.

TECHNIQUES USED

COPE's members developed and validated several questionnaires designed to measure the feelings and needs of clients and to evaluate the three programs at Hill House--the social program, the vocational program, and the co-op housing program. The questions for the instruments were based on COPE members' life experiences and suggestions from other Hill House clients. Two of the three instruments used were structured questionnaires. The third instrument was an open ended survey that was administered to the clients in the cooperative.

FINDINGS OF EVALUATION OR MONITORING

The client-developed measure (CDM) questionnaire was the first client instrument to be administered and completely validated by COPE at Hill House. This evaluation demonstrated both to the agency and to COPE that clients can design a valid and reliable instrument. The results of the needs assessment and program evaluation instruments, though promising, are not final. The status of each instrument is as follows: the needs assessment questionnaire has been administered a second time; the social program questionnaire has been administered to a larger sample of clients; and the vocational program instrument is being revised and will be administered a second time. The transitional housing interviews are complete.

Preliminary findings indicate that both the needs assessment and program evaluation instruments do measure client satisfaction. COPE members believe that the initial evaluation results suggest possible changes in Hill House programs; however, no formal conclusions will be drawn until the survey results are completed.

RECOMMENDATIONS

Since the initial findings of the needs assessment and program evaluations are still being reviewed by COPE members, no formal recommendations have been developed concerning these survey results. The successful involvement of consumers in developing the CDM, however, led to certain overall recommendations. For example, it was recommended that the CDM group expand its activities to include program evaluation and needs assessment, and to increase consumer representation in these evaluation functions. Furthermore, it was recommended that clients increasingly represented on the Hill House Board of Trustees and in other agency programs. Both of these recommendations have been implemented successfully.

STEPS TO ENSURE IMPLEMENTATION

The major implementation efforts to date have focused on the results of client involvement in the CDM. During the past five years, a strong cooperative relationship has developed between the COPE group and Hill House staff which, in turn, had led to increased visibility of consumers in agency functions. COPE has further enhanced its credibility by disseminating its process and news of its progress within the State of Ohio and throughout the nation by making presentations at various mental health conferences, meetings, and workshops. In addition, both COPE and Hill House staff have prepared articles for several mental health publications that describe the consumer-based evaluation system.

In order to implement the final results of the program evaluation and needs assessment, COPE

organized a daytime auxiliary of Hill House clients (COPE II) who are responsible for developing groups and activities that are indicated by the questionnaire responses.

EXTENT OF IMPLEMENTATION

As evidenced by the existing level of participation of the COPE group, the recommendations concerning increased client involvement in evaluation activities have been implemented. Moreover, there is increased client representation on the Hill House board of trustees, and two paid COPE coordinators, both former clients, were recently hired to focus exclusively on evaluation activities.

Despite the lack of formal recommendations emanating from the program evaluations and needs assessment, several changes have already been made in agency operations because of COPE's established credibility in earlier activities. For example, the original staff-developed assessment instrument was replaced by CDM; the needs assessment questionnaire is now used as an intake instrument for all new clients; and the transitional housing residence limitation has been extended, when appropriate, from six to nine months. In addition, COPE II and the COPE coordinators are making daily changes at Hill House that reflect new programs and activities such as Reaching Out, a group that focuses on group skills, parenting (for those Hill House members who are parents), and food and clothing collection. Weekend activities planned by clients such as picnics, potluck suppers and trips to community areas of interest also have increased and are now a growing part of Hill House. Lastly, because many clients wanted Hill House to attract outside speakers to address legal rights, a monthly seminar was initiated that has been very well attended by consumers.

SPECIAL BARRIERS OR SUPPORTS

Changes in agency research directors have been a hindrance to COPE's work. On the other hand, without the technical support of the research directors, COPE would not have been able to achieve what it did.

The need to educate new members on the complexities of COPE's research has, from time to time, temporarily slowed the group's momentum; however, COPE's "hair-down" rap sessions about individual mental illness experiences not only keep the "feeling" base alive for the research but also apppear to release the tensions of new members and to motivate them to participate.

Hiring two former Hill House clients as COPE coordinators has been a tremendous support. These individuals are responsible for administering the questionnaires, organizing and leading meetings with staff and clients, soliciting feedback, and exploring implications for improving the quality of services.

RESOURCES AND COSTS

Each COPE member donates at least 100 hours annually to the organization. Some members, especially the chairperson and vice chairperson, give more than 100 hours. Other staff time allocated to COPE activities is as follows: research director--25 percent; two COPE coordinators--each 100 percent; project secretary--60 percent; statistician--10 percent; and data processor--30 percent. Some monies are also allocated for reproduction, keypunch rental, clerical supplies, tape cassettes (all meetings are recorded), travel expenses, and computer time. Financial support for all of COPE's projects has been provided by the office of program evaluation and research of the Ohio Department of Mental Health and the Cleveland Foundation.

ADDITIONAL COMMENTS

The clients at Hill House are enthusiastic about COPE's work and they identify with, and support, the organization. Furthermore, these clients are anxious to share their experiences in an evaluation context in order to expand and strengthen COPE's scope of work.

36. Consumers Evaluate Community Residential Programs

Cheryl Fanning

Community Support Project, Arizona Department of Health

SUMMARY

Three advocacy groups in the State of Arizona participated in a review of a community mental health residential treatment system for chronically mentally ill (CMI) individuals that was initiated as a result of legislation enacted in April 1980. The legislation (ARS 36-550) provided funds for planning and implementing a statewide community residential treatment system. The Arizona Department of Health's bureau of

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community services was assigned the task of developing and monitoring contracts for these community residential and day services. Mental health agencies in five regions of the State were awarded funds to provide a continuum of residential services. In order to solicit citizen views regarding these programs, advocacy groups were requested to visit the programs and submit their comments to the Department.

TYPE OF ORGANIZATION

Three of the five advocacy groups asked to participate in the review of the residential and day programs agreed to complete the evaluation. They included: Education, Advocacy, Support and Experience (EASE) from Tucson; Mental Health Advocates Coalition; and the human rights committee of the Arizona State Hospital. All of these groups are composed of consumers, family members, or other advocates for improved mental health services in Arizona.

EVALUATORS OR MONITORS

Reviews of the residential programs in seven Arizona cities were conducted by: a woman with a mental illness and her husband from EASE; the father of a CMI person from Mental Health Advocates Coalition; and three persons from the human rights committee--a nurse, a rehabilitation coordinator, and a patient advocate from the State hospital.

REASONS FOR THE EVALUATION OR MONITORING

The Arizona Department of Health's bureau of community services staff are responsible for monitoring contracts under ARS 36-550. The assistance of advocacy groups was solicited in order to evaluate the quality of residential services and to develop funding recommendations for the upcoming year.

LEVEL OF PARTICIPATION

Each advocacy group visited the programs at different times in order to conduct independent reviews. Reviewers scheduled the site visits with a contact person from each agency.

TARGET OF EVALUATION OR MONITORING

The focus of the evaluation were the five primary contractors (and additional agencies with which they subcontract), that are funded under ARS 36-550. Northern Arizona Community Guidance Center, located in Flagstaff, is responsible for service delivery across four counties. The counties range in population from 60,000 to 80,000; one county is larger in area than the State of Rhode Island. Several small day-treatment and residential programs provide services in these counties. Behavioral Health Agency of Central Arizona is located in Pinal County, which has a population of approximately 1,000,000. La Frontera Center, located in Tucson, funds several residential programs that were evaluated by advocacy groups. Community Behavioral Sciences and its two residential services subcontractors are located in Maricopa County--the most populated county in the State with 2,000,000 people. Maricopa County department of health services is also located in Maricopa County, as is Arizona State Hospital. A large percentage of deinstitutionalized chronically mentally ill persons reside in this county.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

This evaluation focused on three major areas: (1) physical aspects of the residence including space and cleanliness; attractiveness and comfortableness of furnishings; and presence of plants, wall hangings, personal belongings, and other items that contribute to a homelike atmosphere; (2) activities in which the residents were engaged such as making crafts, participating in socialization groups, reading and discussing current events in the newspaper; and (3) observations of staff interactions with patients.

In addition, evaluators were asked to compare the existing level and quality of services to the previous year when the services were first initiated and to provide their overall impressions of the program. Most importantly, evaluators had to determine if they could recommend a facility for a loved one who was mentally ill. Other recommendations were also solicited.

TECHNIQUES USED

Reviewers made site visits to each facility in the State using an open ended questionnaire to record their observations and recommendations. The questionnaire, developed by the community support staff, focused on five key areas: (1) a description of the physical structure; (2) a description of residents' activities; (3) an assessment of staff and resident interaction; (4) a comparative analysis with last year's evaluation; and (5) an overall impression of the program.

FINDINGS OF EVALUATION OR MONITORING

Although the specific findings of the evaluators varied for each facility, overall, their impressions of the facilities were positive. As several reviewers commented, "I would feel comfortable in placing a person I care about in this facility." Many comments addressed the physical environment of the residence and included such descriptions as "neat," "clean," "a healthy environment," or "the area was clean, roomy, well-

lighted, cooling and heating excellent." Several comments focused on the need for better and sturdier furniture. All of the reviewers commented on the location of the program. Several individuals indicated that the program would be better located away from an inner-city, congested area. One reviewer noted that the location of the residence away from the central city area may have contributed to the positive attitudes of the residents. Another reviewer, however, observed that the residence was too far way from the nearest town and the crisis center.

Other comments focused on the programing and administration of the various facilities. Several evaluators expressed their reservations about housing CMI's with alcoholics and drug abusers in the same facility. Other reviewers were impressed with the emphasis on promoting independence in some of the facilities. One reviewer noted that a day-treatment program also emphasized mainstreaming and promoting independence for its clients. Another evaluator, however, had an overall negative impression of a facility because of the physical environment--i.e., the facility was overcrowded and had a dreary atmosphere.

RECOMMENDATIONS

Advocates made many recommendations concerning the findings described above. The recommendations were submitted to the Arizona Department of Health's bureau of community services staff who, in turn, shared them with the directors of the five major contracting agencies. The recommendations focused on several key concerns: physical plant considerations, location of the facilities, client groupings, and possible expansion of the programs. Some of the specific recommendations included: moving one residence closer to the nearest town in order to access the crisis center; providing heavier and sturdier furniture in the living areas and establishing more units at this particular site; examining the possibility of separate living quarters for the chronically ill (CMI), alcoholics and drug abusers; developing more transitional housing; relocating an entire program (17 persons) to a better physical environment; and expanding and continuing day programs and other residential programs for those on waiting lists. One reviewer noted: "There is a need for ways to be found to move those [CMIs] in this program [who are ready] out into the community at large."

STEPS TO ENSURE IMPLEMENTATION

Department of health staff use the evaluative comments prepared by the mental health advocates in allocating funds to providers. As such, providers have a fiscal incentive in upgrading their facilities.

EXTENT OF IMPLEMENTATION

With respect to the most recent set of evaluations conducted, certain agencies with identified deficiencies in their physical plants have already taken some steps to locate other residential facilities. One of the facilities that received a poor rating last year--the first year the evaluation was conducted by the advocates--received a fairly high evaluation this year because of the marked improvement in its operation.

SPECIAL BARRIERS OR SUPPORTS

One of the advocates made a generally poor impression on the staff and the clients in the facilities, including being late for appointments and attempting to do "therapy" with a resident. This led to several written complaints to the department of health about this advocate's demeanor. In addition, the geographic distances involved and the extensive amount of time necessary for this type of program review limited participation in the evaluations. Only a few members from three advocacy groups actually made site visits and prepared written reports.

Staff and residents of most of the facilities welcomed the evaluators and wanted to "show off" their programs to outsiders.

RESOURCES AND COSTS

Approximately $1,200 in community support project funds was used to reimburse the evaluators for travel expenses. Other than preparing the evaluation format and drafting a reimbursement form, community support project staff spent very little time on the evaluation. The advocates spent six full days visiting all of the programs, and additional time was required in order to schedule the site visits.

ADDITIONAL COMMENTS

In general, the evaluators from EASE were pleased with the evaluation form but suggested that, for future evaluations, a checklist with a continuum of choices, i.e., "good," "better," "best," and other format changes might be more helpful. Once the visit was completed this checklist could then be used to write a "transcript" report.

37. A Volunteer Evaluates the Delivery of Mental Health Services to Nursing Home Residents

Margaret S. Munford

In-Home Services Committee of the Washington County Council on Aging

SUMMARY

The In-Home Services Committee of the Washington County Council on Aging conducted an evaluation of the Tualatin Valley Mental Health Clinic's ability to address the problems of elderly residents in nursing homes. The evaluation results were compiled in a final report that was included in the area agency on aging plan prepared by the Washington County Council on Aging.

TYPE OF ORGANIZATION

The In-Home Services Committee, a subcommittee of the Washington County Council on Aging, advises the council on a variety of services provided under the Older Americans Act, including mental health services. In Washington County, these services are provided under a contract with the Tualatin Valley Mental Health Clinic.

EVALUATORS OR MONITORS

This study was conducted by a member of the In-Home Services Committee, who is a retired school teacher with a master's degree in education and a strong background in sociology and psychology.

REASONS FOR THE EVALUATION OR MONITORING

The In-Home Services Committee is responsible for evaluating the Tualatin Valley Mental Health Clinic's contract with the Council on Aging. Each year an evaluation is conducted to determine if the clinic's goals have been met.

LEVEL OF PARTICIPATION

In designing and implementing the study, the evaluator worked closely with the Council on Aging, the director of the Tualatin Valley Mental Health Clinic, the supervisors of the participating nursing homes and, if appropriate, their social directors and the members of the In-Home Services Committee. The evaluator collected and analyzed and wrote the final report.

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TARGET OF EVALUATION OR MONITORING

This evaluation focused on a single dimension of a single agency, that is, the delivery of mental health services to senior citizens in nursing homes as conducted under contract by the Tualatin Valley Mental Health Clinic.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The issues surrounding the delivery of mental health services to elderly persons confined to care centers were the focus of this evaluation. Certain questions pertaining to quality of care and distribution of services were addressed in the evaluation. These included: (1) a breakdown of clients according to diagnosis, age and sex; (2) a distribution of clients according to city of residence; and (3) the number of clients who live in nursing homes (each home was identified) or in their own homes. Client satisfaction with the delivery of mental health services was also assessed. Costs, however, were not included in the evaluation; they were reviewed and evaluated by the finance department of the area agency on aging.

TECHNIQUES USED

First, a list of questions concerning the quality and distribution of services to elderly persons participating in the mental health program was submitted to the clinic staff for completion. Second, consultations were held with the supervisors of the nursing homes and the director of the mental health clinic. Third, the evaluator attended a group therapy class to observe and evaluate the session.

FINDINGS OF EVALUATION OR MONITORING

Discussions with the nursing home managers involved in the mental health clinic program revealed a high level of enthusiasm for the program and the staff conducting it. In their opinion, the mental state of the nursing home patients had improved because of the program.

The therapy session observed by the evaluator was led by a staff person who was knowledgeable and well prepared. The session provided mental stimulation for those attending and a channel for relieving tensions through active participation in the meeting. One woman summed up her feelings about the program by noting that she could do nothing about her physical condition but that these sessions gave her something to think about when she was alone or in bed at night.

The data about quality of care and distribution of services collected by the evaluator also revealed certain findings. In general, the data showed that the age distribution among the clients served by the program was very similar to the age distribution among the general population, but there was a sharp increase in the number of females aged 85 and over receiving services. Moreover, of the 149 clients with identified diagnoses, 63 percent (94 clients) had either organic mental disorders or conditions not attributable to a mental disorder that were the focus of attention or treatment (e.g., adjusting to a major illness or change of residence). In addition, of the 154 persons served by the program, 128 were living in nursing homes--an expected outcome since the program is targeted to clients of nursing homes. Overall, the evaluation results demonstrated that the Tualatin Valley Mental Health Clinic fulfilled its contractual agreement with the Council on Aging in every aspect.

RECOMMENDATIONS

The evaluator recommended that the clinic's contract be renewed for another year, that the Council on Aging increase its service contract with the clinic, when finances permit, and that this report be used as a guideline for future evaluations.

STEPS TO ENSURE IMPLEMENTATION

The recommendations were presented to the members of the In-Home Services Committee. In its annual budget review, the Committee recommended to the Council on Aging that the Tualatin Valley Mental Health Clinic's contract be renewed.

EXTENT OF IMPLEMENTATION

The Tualatin Valley Mental Health Clinic's contract was renewed, and the results of the evaluation were incorporated into the area agency on aging plan prepared by the Washington Council on Aging.

SPECIAL BARRIERS OR SUPPORTS

The evaluator had the support of the directors of the Council on Aging and cooperation from the contractor, clients, and supervisors of the nursing homes.

RESOURCES AND COSTS

There was no cost to the Council on Aging for this evaluation. The evaluator donated approximately 20 to 25 hours to complete the study.

ADDITIONAL COMMENTS

The evaluation of the clinic's program on aging was a pilot project. As such, the final report was designed to provide all of the relevant facts about the program with the least amount of verbiage and to be useful to the recipient audiences. In developing the evaluation format, the guidelines for evaluation that are presented in the *Contract Management Manual for Aging Programs* (Bob Curry and Associates) were used and could be adapted for evaluations of other small social service contracts.

38. Parents Monitor Group Homes to Ensure Quality of Services

Ruth M. Taylor

Parent Monitoring Committee, Association for the Macomb-Oakland Regional Center

SUMMARY

In 1980, the Association of Macomb-Oakland Regional Center (AMORC), a parent advocacy organization, formed a monitoring committee to respond to the concerns of parents and other individuals who have relatives living in community group homes that are serviced through the center. The committee has monitored over 90 group homes to date and all of the concerns, strengths and weaknesses of the homes are discussed among committee members and then reported directly to the director of the Macomb-Oakland Regional

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Center (MORC). An annual report is also presented to the administrators of the group homes.

TYPE OF ORGANIZATION

The parent monitoring committee is a special unit of the Association for the Macomb-Oakland Regional Center--an advocacy group that acts on behalf of the clients receiving services either in Macomb-Oakland or in community programs. The role of the parent monitoring committee is to monitor the agency's group homes to ensure that the persons living in those homes are receiving the best services possible in an environment that enhances and motivates individual growth.

EVALUATORS OR MONITORS

The parent monitoring committee consists of approximately 30 volunteers who have developmentally disabled relatives living either in the natural home or in a community group home. Within the monitoring system itself, there is a core committee of seven persons who, together with other monitors, visit the community homes.

REASONS FOR THE EVALUATION OR MONITORING

In early 1980, AMORC's board decided to form a committee to address the need for monitoring the community system. The members of AMORC believed that such a monitoring system would help to alleviate parental concerns regarding the continuation of quality community homes once parents are no longer living. In addition, the parent monitoring committee would complement two other monitoring efforts already used by MORC: (1) Quality-of-Life Review Teams that are composed of nonprogram MORC staff who visit the homes monthly; and (2) case managers who visit the homes on a weekly basis.

After many organizational meetings, the monitoring committee was ready to begin visiting group homes; however, it was not until June, 1980, that the actual monitoring began. After conducting unannounced visits to more than 70 group homes, discussing concerns, providing suggestions, and winning the praises of the director of MORC, committee members decided that the monitoring system was an asset and should be made a permanent part of the agency's function.

LEVEL OF PARTICIPATION

In conducting group home visits, a monitoring committee core person is always accompanied by another monitor. An evaluation form is filled out by the monitors after each visit, and the home reports are evaluated by the core committee during their monthly meetings. A core person then attends a monthly meeting with the director of MORC and the case management supervisors to debrief them on the results of the monitoring visits.

TARGET OF EVALUATION OR MONITORING

The parent monitoring committee focuses on the quality of services that are provided to the clients living in MORC community group homes. MORC contracts with nonprofit corporations to administer and provide services to clients living in the community. The ages and number of persons living in the homes vary; typically, there are 4 to 12 persons residing in each group home. MORC staff provide the necessary support services to the clients including psychology, psychiatry, social work, nursing, and dietary. In addition, a MORC human rights committee monitors behavior management programs in the community. Community resources such as dentists, doctors, and speech pathologists are also used by group home residents.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The major areas that the monitors review during their home visits include: general quality of life and environmental issues, health, nutrition, and client rights. Among the issues of greatest concern to the committee are nutrition, inside and outside appearance of the home, client-staff ratios and compatibility, barrier-free accessibility for the multihandicapped and the proper storage of medications. Program implementation and client participation in community social and support systems are also of concern to the committee.

TECHNIQUES USED

After organizing the AMORC monitoring committee and core committee, the program was presented to the director of Macomb-Oakland Regional Center, who sanctioned it and notified the group home administrators of its purpose. Guidelines and monitoring procedures were established by the agency and core committee. For example, the core committee meets monthly and, during that time, each person on the committee is responsible for monitoring a certain number of homes with another monitor. Each core person accepts responsibility for monitoring the homes that are within their own geographic location. Checklists for the home visits were developed based on information from the following sources: input from core committee members; checklists used by other agencies; and parental concerns. Finally, in order to enter the group homes, each core person was issued an identification card.

Since June 1, 1980, approximately 4,000 unannounced visits have been made to 114 group

homes under contract to MORC. Unannounced visits are used in order that the monitors can view the conditions in and around the homes in a candid and open manner. Monitors visit the homes in pairs; before entering each home, they make note of the security measures and the upkeep of the grounds. Further, each core person staggers the schedule for the home visits so that each home is observed under different circumstances.

FINDINGS OF EVALUATION OR MONITORING

Overall, the committee members have found that the group homes are functioning like normal home settings. The training courses required before any staff member can work in a group home are excellent (two core persons from AMORC monitored and critiqued this 3-week orientation course). Another significant finding was that the direct care staff turnover was evident in many of the group homes; however, the home managers have been successful in keeping client-staff ratios stable.

RECOMMENDATIONS

Based on the monitoring visits completed during 1980-81, the core committee recommended that direct care staff for group homes receive a salary increase and that a graduated pay scale be used as an incentive to obtain increased wages and to retain staff. The committee also suggested that the pay scale be based on length of employment, experience, and level of responsibility. If implemented, these two recommendations would help to ensure a stable environment for clients living in community homes.

STEPS TO ENSURE IMPLEMENTATION

After reviewing the home visit overviews written by all core committee monitors, the chairperson of the committee compiled an annual report for 1981 that was sent to MORC and shared with the group home administrators. The monitors' concerns regarding the management and staff turnover in a number of the homes as well as their recommendations to resolve these problems were discussed with the administrators. A copy of the annual report was also forwarded to the director of the Michigan Department of Mental Health with a note encouraging his department, based on the monitoring committee's concerns, to seek increased funding in this area.

If a monitoring report should highlight a particular concern in a group home, the MORC reporter has 10 days in which to take corrective action. If the committee believes that appropriate corrective actions are not being taken, it can then contact the office of recipient rights, Michigan Protective and Advocacy Services, or other appropriate agencies.

EXTENT OF IMPLEMENTATION

At a recent meeting of State agency staff that included a member of the board of group home administrators, it was implied that home managers would receive an increase in their operating budget for FY 1982-83. As a result of this increase, a "trickle down" effect would be felt by the direct care staff. In addition to this effort, a much greater increase in wages is needed as an incentive for staff longevity; however, funding constraints have inhibited implementation of this particular recommendation.

SPECIAL BARRIERS OR SUPPORTS

This new and unique way of monitoring group homes was needed, wanted, and eagerly accepted by Macomb-Oakland Regional Center staff. It was so well accepted that the format has been requested by numerous associations for retarded citizens and other organizations and agencies worldwide. In addition, MORC released a special edition of their newsletter, *Transition*, that was entirely devoted to the AMORC monitoring committee and the agency's acceptance of the program.

A major concern of the committee is the recent cutback in funds allocated to regional centers, such as MORC, for group homes. Michigan is currently in a severe recession, and its tax base is shrinking because of a 14-percent-plus unemployment rate. Unless the State's economic circumstances improve, adequate funding for community homes will be in jeopardy.

RESOURCES AND COSTS

Since 1980, the AMORC monitoring core members have donated countless hours to the monitoring program. There has been, however, no estimate developed of the total number of hours spent by the committee members. MORC has provided an office, phone, mail box, mileage, materials, and use of a photocopy machine to the committee.

ADDITIONAL COMMENTS

The committee members are proud of their varying experiences and their ability to "keep an eye" on all group home residents. These activities have brought them together in a common bond. Parents can be candid and open in alerting core committee members about problems in the group homes; they also can be assured that their concerns will be investigated by the committee and monitored until necessary corrective action is taken.

39. Citizens Participate in Planning Services for Older Adults

Ralph W. Accardi

Older Adult Services Advisory Committee of the Marin County Mental Health Advisory Board

SUMMARY

Each year, Marin County Community Mental Health (CMHS) establishes citizen task forces as part of its planning process. Between 75 and 100 persons participate in these task forces and develop recommendations aimed at initiating, expanding, or improving community mental health services. The recommendations are used by CMHS staff to develop the final mental health service plans. Standing advisory committee also may submit recommendations, or they may comment on task force recommendations. All recommendations are based on assessment of needs and evaluation of progress in implementing the previous year's plan. The focus of one task force is services to older adults.

TYPE OF ORGANIZATION

Marin County Community Mental Health Services (CMHS) is a State-mandated, locally controlled agency within the Marin County Department of Health and Human Services. CMHS is responsible for developing and coordinating a comprehensive system of programs to meet the county's mental health needs. These programs address the problems of acute and chronic mental disorders, life crises, developmental disabilities, and drug abuse. Services may be provided directly by CMHS, purchased from community-based agencies, or provided by the private sector.

The mental health advisory board (MHAB) is a State-mandated advisory group that makes recommendations to the mental health director and to the board of supervisors regarding the local CMHS program. The older adult services advisory committee (OASAC) is one of five standing committees that advise the MHAB and/or CMHS staff about services to special populations. In addition to monitoring and advocating on a continuing basis for mental health services directed to older adults, OASAC members also serve on planning task forces in order to evaluate existing services to older adults and to recommend new services as needed. OASAC members service on several planning task forces, such as one on mental health promotion and one on State hospital services, in order to represent the needs of older adults in those specialized areas of planning.

EVALUATORS OR MONITORS

Planning task forces are established for six to eight weeks each year. Task force members are drawn from the community at large and from standing advisory committees. Professionals, lay people, consumers, and service providers generally are represented, with the objective of having broad and balanced representation. There is some continuity of task force membership from year to year, and some new members are added. CMHS staff, MHAB members and staff or board members of agencies that contract with CMHS may not be voting members of a planning task force. However, all meetings are open to the public, and time is provided for the participation of nonmembers.

REASONS FOR THE EVALUATION OR MONITORING

The State requires community involvement in the annual planning process. This county's CMHS also has a policy to provide maximum opportunity for public participation in the development of mental health services. Planning task forces help to implement this policy by making recommendations based on needs assessments, studies of service delivery, and evaluation of the progress made towards implementing the previous year's plans.

LEVEL OF PARTICIPATION

Task forces are charged with: (1) assessing the level of service being provided, (2) assessing the degree to which services meet existing needs, (3) identifying unmet needs, and (4) identifying special problem areas or barriers to service implementation. Task force members collect and analyze all necessary information needed to make the assessments and identify the sources from which this information will come. Task force efforts are assisted ably by CMHS staff. The final report is written by the task force. Standing committees review the final reports and make an independent evaluation of the recommendations. OASAC may support task force recommendations or may add recommendations of its own.

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PROBLEMS OR ISSUES EVALUATED OR MONITORED

Planning task forces address the entire spectrum of mental health services needed by older adults in Marin County. They also assess how well these needs are being met and what further actions are needed to improve the service delivery system for this particular group. The task force's focus may shift from year to year if a particular need appears to be pressing. All of the above issues require assessment of available or needed private sector services as well as service provided by CMHS.

TECHNIQUES USED

In order to formulate a reasonably accurate picture of the service system as it exists, a variety of data sources are used. These include county demographic data, statistical case data, presentations by informed professionals active in the field of mental health, experiences of "self-help" groups and other human service agencies and organizations.

FINDINGS OF EVALUATION OR MONITORING

Without exception, the evaluation portion of the planning process has shown a real commitment on the part of the mental health staff to provide quality services within the limits of its resources. The use of a citizen's planning team is viewed positively by the director and staff. Consequently, response to the task forces' reports and recommendations have been good. Some significant changes and improvements have been brought about in patterning the total mental health delivery system on recommendations made by planning programs, e.g., mobile geriatric evaluation team, establishment of geriatric and minority service coordinator positions, etc.

RECOMMENDATIONS

Recommendations listed in the report for the 1982-83 planning year included:

- Maintaining linkages throughout the community with other providers of services to older adults
- Monitoring the service utilization rates of older adults and attempting to increase utilization of mental health services
- Formulating an overall gerontology training plan for various audiences including staff from acute care hospitals, skilled nursing facilities, and CMHS

STEPS TO ENSURE IMPLEMENTATION

The planning task force's report is carefully prepared and documented to support its recommendations. Information and ideas from staff are solicited along the way to ensure that proposed actions are reasonable and attainable. Copies of the draft service plan are made available to task force members. They evaluate the plan against the recommendations made and have the opportunity for additional suggestions. The OASAC makes its position known with respect to the recommendations. The draft plan is then presented to the mental health advisory board at a public hearing, at which the planning task force is represented.

EXTENT OF IMPLEMENTATION

It must be recognized that this is a continuing process of planning and evaluation from year to year, rather than a specific project with finite parameters. Most recommendations made by planning task forces have been accepted in principle. When resources permit, they have been incorporated immediately into the mental health service plan. When resources are insufficient, recommendations are not discarded by are listed as "unfunded services" for possible future implementation. These unit recommendations are carried forward from year to year in the planning process if the need still exists.

RESOURCES AND COSTS

Paid staff time is approximately 80 hours per task force per year. Paid clerical support is 40 hours. Volunteers donate 160 hours and CMHS provides staff support services.

ADDITIONAL COMMENTS

A process that includes public participation in developing an action plan tends to carry more credibility and acceptance. Furthermore, as more and more people become involved in the planning process from year to year, the level of awareness within the community will increase, providing support for continued funding of mental health services.

40. CMHC Board Members Incorporate Evaluation Results into Agency Planning

David L. Silver and Donald A. Craig

Northeast Kingdom Mental Health Service

SUMMARY

As part of its evaluation responsibilities, the program and evaluation committee of the Northeast Kingdom Mental Health Service (NKMHS) board of directors conducts annual interviews with individual staff members who represent the agency's various services and support systems. The results of these interviews together with other program information are presented to the board of directors in the form of specific recommendations and are also included in the agency's annual evaluation report. Moreover, the committee's recommendations become incorporated into the agency's policy and planning process.

TYPE OF ORGANIZATION

The program and evaluation committee, one of several committees of the NKMHS board of directors, is composed of up to eight members--two-thirds of whom are from the agency's governing board. Committee members are appointed by the board president and serve from one to three or more years.

The committee functions under periodically reviewed policies and procedures; its four primary responsibilities include the following: (1) to establish long range agency goals and priorities; (2) to review and evaluate existing programs on an ongoing basis; (3) to assist in the development of new programs; and (4) to meet with staff members annually and make recommendations to the board accordingly.

EVALUATORS OR MONITORS

The program and evaluation committee presently consists of the following: a former district school administrator, now administrator of an extended care facility; the administrator of a convalescent center; a former mental retardation professional, now owner of a general store; a former social worker, now a museum curator; a retired businessman; and a practicing attorney.

REASONS FOR THE EVALUATION OR MONITORING

Evaluation has been an important part of Northeast Kingdom Mental Health Service (NKMHS) activities since the early 1970s. Board member involvement in evaluation has developed gradually and was formally incorporated into the committee structure of the board of directors with the enactment of the Community Mental Health Centers Amendments of 1975 (Public Law 94-63). By 1977, the agency bylaws were amended to include a program and evaluation committee. Since that time, annual agency evaluation reports have been prepared with assistance from the program and evaluation committee. As defined by NKMHS staff and board members, the agency's evaluation process is not related so much to research as it is oriented to pragmatic identification of, and solutions to, problems, and is an essential part of the agency's planning cycle and management practices.

LEVEL OF PARTICIPATION

As part of the agency's evaluation process, committee members are involved in developing interview guides, conducting interviews with a variety of knowledgeable individuals (key informants), including program staff under contract to NKMHS, and other related activities. Much of the program and evaluation committee's work, however, is done with the assistance and cooperation of the agency's administrative staff. For example, committee members and staff conduct monthly meetings throughout the mental health service area concerning evaluation and planning issues.

TARGET OF EVALUATION OR MONITORING

The agency's ongoing evaluation efforts are focused on its internal performance and on the mental health needs of the catchment areas. NKMHS serves a poor, rural area that encompasses three counties with a total population of 35,000. This area has consistently ranked at or near the top in statewide needs assessments. Even though the area served by NKMHS has certain documented needs, the agency is providing the 12 service elements and the compliance features that were mandated by Public Law 94-63. The agency has inpatient service contracts with two small general hospitals, but separate psychiatric units within those facilities have been discouraged. The State hospital, which may be a distance of 30 to 100 miles away, provides backup

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services for the acutely ill and severely chronic patients. For general mental health services, NKMHS employs the only full-time psychiatrist in the area, who is a member of the National Health Service Corps. Some contracted part-time psychiatric service is also available to the agency. Although private practice in mental health professions--other than psychiatry--is growing, it is evident that such services will not meet area needs in the foreseeable future.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Evaluation studies conducted by committee members have addressed a number of concerns: citizen awareness and satisfaction, consumer satisfaction, unmet needs, setting priorities for services, performance, public image, utilization of emergency services, utilization of psychotropic drugs, adequacy of facilities, and others.

TECHNIQUES USED

The primary techniques used to evaluate specific agency concerns were: (1) questionnaires are mailed to board members, staff, and other providers, including area physicians (responses are designed to assure anonymity and to encourage additional comments); and (2) interviews are conducted annually with selected staff. The questionnaire consists of a series of open ended questions, several awareness and acceptability questions and a scale with which to rate the performance of the agency. In its interview guide, committee members ask staff associated with each agency program to provide information on such issues as the quantity and quality of services, the effectiveness of various treatment modalities, the strengths and weaknesses of existing programs, and recommendations for program improvement. Staff responses are supplemented with information on units of service, unit costs, and budget performance.

FINDINGS OF EVALUATION OR MONITORING

Since the evaluation findings may vary from year to year, this section presents a summary of selected questionnaire responses for FY 1982. For example, board members, staff, and providers were asked to rate the agency's performance and public image on a scale from 1 to 10. Based on a combined average rating of all respondents, the agency's overall performance was ranked higher (8.0) than its public image (6.9). In terms of these two indicators, the three respondent groups did not differ significantly in their responses; however, NKMHS staff did rate their performance and public image higher than the other two respondent groups.

In addition, board members, staff, and other providers were asked to rank 14 programs, services, or activities by priority. Based on a combined ranking of all responses, the top three priority areas included: outpatient counseling, emergency services, and alcohol programs. Although specialized childrens' services ranked fourth among all of the combined responses, they were one of the services with the greatest disparity between respondent groups, e.g., board members ranked them second, staff third, and providers tenth.

RECOMMENDATIONS

For FY 1982, the committee presented two sets of recommendations to the NKMHS board. Based on information collected through the questionnaires, the following types of recommendations were made: (1) future survey instruments should be more precise and should include sampling of client and citizen opinions; (2) the program and evaluation committee should meet with the board's public education committee to explore ways of promoting prevention programs; and (3) efforts to educate the public regarding agency prevention programs should be intensified.

The committee's recommendations, on the basis of staff interviews, included, but are not limited to, the following: (1) an employee assistance program, with a prepared timetable, should be actively pursued; (2) the lack of privacy in waiting rooms should be addressed; (3) steps should be taken to ensure that a backup is available at all times for receptionists who do client intake; (4) billing policies and procedures should be reviewed; (5) vocational education should be included as an optional client service in the training-in-living-skills day treatment program; and (6) utilization of specialized foster parent homes should be increased.

STEPS TO ENSURE IMPLEMENTATION

The committee reviews its recommendations at every monthly meeting to ensure that they have been carried out and incorporated into the ongoing planning functions of the agency. In addition, the recommendations are discussed in one or more of the weekly NKMHS administrative staff meetings. The center's executive director will also respond to the committee either verbally or in writing regarding the implementation of its recommendations.

EXTENT OF IMPLEMENTATION

With respect to the recommendations made in FY 1982, the following events have occurred: (1) a timetable has been adopted for the employee assistance program; (2) steps have been taken to correct the lack of privacy in NKMHS waiting rooms and to provide backup staff for receptionists; (3) billing and vocational training issues

are still under study, but a number of staff hours have already been spent on developing improvements, e.g., a new fee schedule will soon go into effect; and (5) increased utilization of specialized foster parent homes has been accomplished, thus increasing the viability of that program.

SPECIAL BARRIERS OR SUPPORTS

A lack of resources constitutes the greatest barrier to the implementation of evaluation activities. At the same time, certain Federal and State agencies continue to require evaluations and, therefore, have prompted agency board members and staff to identify and pursue evaluation activities. In addition, monitoring the implementation of evaluation results is difficult because limited resources constrain implementation of some projects and more pressing problems divert the attention of agency staff. Committee members, however, have been willing to travel throughout the service area to ensure that their evaluation results are carried out.

One particular problem in using staff interviews for evaluation purposes is the potential risk of entangling individual personnel matters in the process. In 1982, a special effort was made to avoid personnel issues. Moreover, there is an active NKMHS personnel committee, and a routine grievance procedure available to any staff person.

RESOURCES AND COSTS

In 1982, each member of the program and evaluation committee contributed an average of about 85 hours or a total of 510 hours to evaluation activities. Clerical and administrative staff time spent on evaluation related issues amounted to another 160 hours; the NKMHS planner/evaluator also spent some of his time providing necessary statistical information to committee members.

ADDITIONAL COMMENTS

The sense of importance and accomplishment that is felt by committee members helps sustain their high level of commitment to, and involvement in, the evaluation process. Moreover, their direct contact with staff during the process helps to strengthen staff-board relationships.

Policy and planning formulation resulting from evaluations or from problem resolution is a complex process in an organization where participatory democracy is encouraged and where the organization must respond quickly, flexibly, and effectively to changes in its operating environment. Ideally, evaluations or problem resolutions should result in the development of policies that can be used more than once, thereby reducing the energy required by the agency to handle recurring problems.

41. A Key Informant Survey to Determine Accessibility and Acceptability of Mental Health Services

Kevin M. Kindelan, George F. Mailly, and Kathy B. Hayes

Winter Haven Hospital Community Mental Health Center

SUMMARY

In 1981, the program evaluation and research committee of the Winter Haven Hospital Community Mental Health Center (WHHCMHC) conducted a needs assessment study using a key informant approach. Information was obtained from 49 individuals regarding their perception of mental health problems and needs within the community as well as their assessment of the visibility, acceptability, and accessibility of the center's services. A final report presented the rationale for the study, the methodology, the results, and specific recommendations to the WHHCMHC's director and the coordinator of the hospital's quality assurance department.

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TYPE OF ORGANIZATION

The needs assessment study was conducted by the program evaluation and research committee of the Winter Haven Hospital CMHC. The WHHCMHC is a comprehensive community mental health center that receives funding primarily through State and local resources. It began operations in 1967 and was the first community mental health center in Florida. The CMHC is part of a general hospital and is served by the hospital's board of directors.

EVALUATORS OR MONITORS

The program evaluation and research committee is composed of three professionals employed full-time by the center: two psychologists and a social worker. The responsibilities of the committee are threefold: (1) to advocate for evaluative and research activity with the

WHHCMHC, (2) to provide necessary evaluative data for the WHHCMHC, and (3) to serve as consultants for staff who are performing exhaustive or research studies.

REASONS FOR THE EVALUATION OR MONITORING

The needs assessment study, conducted in the fall of 1981, was part of an ongoing evaluative effort initiated by mental health center staff. For example, in 1980, a continuity-of-care study and a consumer-satisfaction study were also completed. Up until the current study, the most recent needs assessment data for the WHHCMHC was from an epidemiological survey completed in 1974.

LEVEL OF PARTICIPATION

The program evaluation and research committee was responsible for planning, designing and conducting the survey, as well as analyzing the data for the needs assessment study. In addition, the committee was responsible for writing and distributing the final report. In this effort, citizens are involved as solicited reactors in that their views and concerns regarding the existing local mental health system were incorporated into the study.

TARGET OF EVALUATION OR MONITORING

The needs assessment study focused primarily on the area surrounding Winter Haven, Florida, and the multiple services offered by the center. Winter Haven and the environs have a population of approximately 100,000. There is a sizable population of school age (approximately 24 percent of the population is under the age of 14) and about 45 percent of the population falls between the ages of 25-64 years.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

This study had four primary objectives: (1) to determine the area's mental health related problems and service needs, (2) to assess the visibility of existing center services, (3) to assess the acceptability of existing WHHCMHC services, and (4) to assess the accessibility of existing WHHCMHC services. A secondary objective was to assess the respondents' satisfaction with the needs assessment questionnaire.

TECHNIQUES USED

The technique utilized was a key informant approach. The key informants were identified by the program evaluation and research committee as individuals in the community who were aware of its mental health problems and needs. A total of 49 out of 56 key informants contacted actually participated in the study. These individuals, who were nearly equally divided between males and females, represented a wide array of human service delivery and other specialties. For example, some key informants worked in the areas of elementary and junior high guidance counseling, social services, ministry, law enforcement, employment counseling, hospital administration, homemaking, and county health department nursing administration.

Each of the 49 key informants was mailed a packet containing a letter describing the study and requesting their involvement, and the needs assessment questionnaire. The questionnaire was a 22-item instrument, derived from other sources and adapted for the center by the committee. An administrative staff member contacted each key informant soon after the packet was received in order to schedule a telephone interview. Most of the informants were interviewed over the phone by a member of the program evaluation and research committee, but a few mailed in their questionnaire without an interview.

FINDINGS OF EVALUATION OR MONITORING

Key informants identified two problem areas of greatest concern: substance abuse (i.e., alcohol or drug abuse); and family issues (i.e., family problems, marital problems, child abuse and spouse abuse). The mental health service reported to be most needed was public information about mental health. Classes in job-seeking skills, crisis intervention, parenting skills, and services to abused victims also rated highly in terms of perceived need.

Most of the key informants were aware of the center's services. A service with high visibility was the center's 24-hour telephone counseling services for the elderly. In terms of the accessibility of services, the key informants indicated that a major problem was the "stigma" associated with receiving mental health services. Other significant problems related to accessibility included transportation, wages lost or time off from work, and the cost of services. The attitudes of staff and the location and appearance of the facilities were infrequently mentioned as reasons for inaccessibility. In terms of acceptability of the center's services, there was general satisfaction with the staff's response to a referral. Some key informants, however, were dissatisfied with the lack of feedback on a referral from center staff.

RECOMMENDATIONS

As part of its final report, the program evaluation and research committee submitted seven recommendations based on the needs assessment study to the Winter Haven Hospital CMHC's director. The recommendations included four

areas that should be considered by the center: (1) providing divorce-support groups; (2) providing classes in step-parenting skills; (3) offering outpatient services during the evening hours; and (4) reviewing the policy and procedures regarding mental health professionals who continue to work with a former or current client who is admitted to the inpatient suite. The remaining three recommendations were oriented more toward action. They included: (1) developing programs to foster constructive community attitudes regarding emotional problems and obtaining mental health services; (2) developing a workshop that would focus on referral procedures and issues (i.e., referring the resistive or apprehensive client, initiating feedback on clients referred for service); and (3) developing a forum for the mutual exchange of ideas between inpatient unit staff and area mental health professionals.

STEPS TO ENSURE IMPLEMENTATION

The final report and the seven recommendations were submitted by the Winter Haven Hospital CMHC's director to the task force on center policies, an interdisciplinary advisory group composed of treatment and administrative staff, and to the coordinator of the hospital's quality assurance department. During one of the weekly meetings of the task force on center policies, the report and recommendations were presented and discussed by the chairman of the program evaluation and research committee.

EXTENT OF IMPLEMENTATION

Although the task force on center policies did not adopt any specific implementation plans for the recommendations, it is hoped that the final report and recommendations will provide a basis for future administrative decisions or programmatic changes.

SPECIAL BARRIERS OR SUPPORTS

No major barriers to, or supports for, the evaluation effort were present.

RESOURCES AND COSTS

The three members of the program evaluation and research committee spent approximately 120 hours over a 4-month period in designing, implementing, and writing up the study. Approximately 20 hours of clerical assistance were used to set up interview times and to type the various materials and final report. Key informants contributed approximately 37 hours, or about 45 minutes individually, to the study.

ADDITIONAL COMMENTS

A future refinement of the study will be to utilize a specific sample of key informants and to inquire about their perception of a limited range of mental health issues. For example, a sample of citizens involved primarily with children, adolescent, and family issues (i.e., parents, teachers, guidance counselors, judges, law enforcement personnel, and others) could serve as key informants. These persons could be asked to identify the mental health needs and problems within a specified category (i.e., children, parenting, etc.).

42. Volunteers Assess the Feasibility of Closing a State Psychiatric Center

William P. Benjamin

Central Islip Psychiatric Center Board of Visitors

SUMMARY

In 1982, the Central Islip (New York) Psychiatric Center board of visitors conducted an evaluation of a proposal to close the State facility. Board members examined the need for the center and how the patients could be cared for in other facilities. The board presented a position paper to the New York office of mental health that included the board's recommendations and rationale regarding the closing of the State hospital.

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TYPE OF ORGANIZATION

The Central Islip Psychiatric Center board of visitors is composed of seven volunteers who are appointed by the Governor of the State of New York. Three of the seven members must be relatives of current or former patients. All of the board members reside in the catchment area that is served by the center. It is the responsibility of the board to monitor the quality of care of patients at the center. The board also has a responsibility to evaluate and to offer advice on any proposed change or alternative use for the facility.

EVALUATORS OR MONITORS

The assessment was conducted by the six members on the board of visitors (one position was vacant at the time of this study). Two of the members are social workers, one is a college professor, one is a Roman Catholic priest, another member is an executive with the telephone company, and one member is retired and the mother of a patient in the facility.

REASONS FOR THE EVALUATION OR MONITORING

In 1982, a proposal was made by the township of Islip and the New York Institute of Technology to purchase the 550 acre campus where the psychiatric center is situated. The backers of the proposal wanted to convert the facility and property into a college campus and to locate high-technology industry adjacent to the college. This plan was well received by the community since it held out the possibility of revitalization for the town. The plan, however, called for the displacement and movement of the patients at the facility. As such, the board members determined that an evaluation of the feasibility of such a proposal was warranted.

LEVEL OF PARTICIPATION

The board members were involved in varying degrees of participation in this evaluation, i.e., collecting data, conducting interviews, and preparing written reports. The board decided that since it was representative of the community, an ad hoc committee be established that would consist of the various factions that would be affected by the proposed change. Therefore, employees, patients, and other community residents became part of the ad hoc committee. It was the purpose of the committee to supply data concerning the issue of closing the hospital to the board and to assist the board in analyzing the data.

TARGET OF EVALUATION OR MONITORING

The evaluation focused on the care provided to more than 2,000 patients at the psychiatric center. The evaluators looked at the type and level of care received by the patients as well as the components of care.

The catchment area for the Central Islip Psychiatric Center is the county of Suffolk with a population of more than 1,300,000 persons. In addition to the psychiatric treatment available at the center, the facility also contains a 99-bed medical and surgical hospital. This hospital serves not only the 2,000 patients at Central Islip Psychiatric Center, but also the medical and surgical needs of three other regional psychiatric centers. These other centers have a combined population of 6,000 patients. The facility also has a number of outpatient community clinics that are scattered about the country.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The evaluation study analyze the possibility of patients receiving the same level of care in other facilities or programs and the availability of beds for such care. Further, the evaluation studied the effects of relocation and transfer on patients, and the need for a medical surgical hospital in the region.

TECHNIQUES USED

Interviews were conducted with a variety of key informants, or knowledgeable individuals, for the feasibility study. Board members and others interviewed patients and families regarding their feelings about the hospital and their ability to accept relocation. A demographic study was also conducted regarding the accessibility of community services for patients who would be relocated. Staff associated with various community and advocacy groups were contacted in order to ascertain their interest in serving this patient group. In addition, other facilities in the region were surveyed to assess service availability.

FINDINGS OF EVALUATION OR MONITORING

The board members and others found that most of the patients, especially the elderly patients, feared relocation and transfer. Most of them looked at relocation in terms of losing their home. Moreover, the consensus of the interviewees was that moving the elderly patients would have a traumatic effect on their psychological well-being. It was also found that there was a dearth of nursing home beds and family care beds in the community to serve the geriatric population. In terms of the medical-surgical services issue, it was found that patients from other psychiatric centers were receiving inadequate care in community hospitals for these problems; therefore, there was a continued need for a medical-surgical hospital to serve the region. In the final analysis, the evaluation results suggested that while closing the facility might bring some economic advantages to the community, it would present some severe problems in terms of providing adequate patient care.

RECOMMENDATIONS

Based on the evaluation results, the board felt that the facility should not close. The board, however, did feel that the community's economic needs should also be addressed. In examining the physical plant and other structures on the hospital campus, the board concluded that the hospital could consolidate and utilize half of the campus

while selling the other half to the town and the college. In this manner, both the needs of the patients and the community residents would be served.

STEPS TO ENSURE IMPLEMENTATION

The board attempted to sell its plan to as many factions of the community as possible. For example, the board of other State hospital facilities as well as community and advocacy groups were contacted regarding the advantages and disadvantages of the board's plans. In addition, the Governor and certain State legislators were contacted.

EXTENT OF IMPLEMENTATION

Although the board's plan was well received by other facility boards and by the State Association of Boards of Visitors, the State office of mental health did not accept the plan. It was evident that the office of mental health could not approve the board's plan since it did not fully meet the needs of the State college. A compromise, however, was finally reached whereby the psychiatric center would continue to serve the geriatric population in the region and to provide medical-surgical services for those patients. The population of the facility would be reduced to 550 patients; 1,450 patients would be transferred to other facilities in the region. Under this plan, the center would be consolidated, but not closed, and the town and college would purchase approximately 500 acres of the existing hospital property.

SPECIAL BARRIERS OR SUPPORTS

A great deal of support for the study came from the hospital staff and advocacy groups. A major barrier was the lack of understanding of the needs of the mentally ill, especially by groups such as the civic associations which were more interested in increasing real estate values.

RESOURCES AND COSTS

The board conducted this evaluation without a budget and, when necessary, absorbed those costs that did occur. In addition, State hospital and other agency staff donated their time to the board. Although the total number of hours spent on the evaluation is difficult to estimate, some board members donated over 300 hours to the study.

ADDITIONAL COMMENTS

Because of its commitment to quality patient care and to the patients themselves, the board became a well-respected group within the community. As a result of the evaluation, the board gained a great deal of visibility, and its ability to secure additional resources for the patients at the facility was enhanced.

43. Emergency Services in High Point

Barbara Geddie

High Point Mental Health Association

SUMMARY

The High Point Mental Health Association (MHA) first identified the need for local 24-hour emergency services in its community in 1972. The High Point catchment area is unique in that it includes the second and sixth largest cities in the State. As a result, the area requires a center that provides a full range of services in each city, and an overall area office to direct and coordinate the two facilities. High Point citizens had to travel 20 miles to the other center for emergency services when the local center was closed, and area office staff were reluctant to establish after-hours emergency services in High Point. The need for such services also was documented in 1975 by the United Way and the High Point MHA in a survey of community mental health needs, and by the local mental health center director who conducted a survey in 1981. Also during the years, the need continued to be identified through the county advisory board and through MHA representatives at site reviews conducted by the National Institute of Mental Health and the North Carolina Division of Mental Health. The county advisory board and MHA contacted county commissioners. A model for emergency services was presented to the county commissioners, and via radio to the public with support by the local MHA chapter. The model was approved by the county commissioners and area authority and is

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now being implemented.

TYPE OF ORGANIZATION

The High Point Mental Health Association is composed of catchment area residents who are interested in the delivery and quality of community-based and institutional mental health services. The board of directors is elected from the membership, and two-thirds of the board must consist of persons not professionally engaged in the mental health field. Employees of public mental health agencies are not eligible for board membership. The three ex officio members are: the director of the High Point Mental Health Center; the county program director who is responsible for the catchment area program (including book centers); and a United Way liaison person. The board has representation according to race, sex, religious affiliation, and economic level consistent with the characteristics of the catchment area. The board's role is to advocate for the mental health needs of local citizens, and to monitor and facilitate service quality and the center's responsiveness to community needs. The association makes recommendations directly to the High Point branch of the Guilford County Mental Health Center, and indirectly to the county via representation on the advisory board to the county mental centers, to the area board (which is the mental health authority) and to the regional office of the North Carolina Division of Mental Health through citizen participation in their onsite review team.

EVALUATORS OR MONITORS

The evaluation was coordinated by the local MHA and the team was composed of eight housewives, six clergy, two private practitioners (a psychiatric nurse and a psychiatrist), one congresswoman, four educators, one doctor, one retired educator, two businessmen, and one graduate student.

REASONS FOR THE EVALUATION OR MONITORING

The continued monitoring was necessary because the area office remained reluctant for 10 years to look seriously at expansion of emergency services locally. The local MHA chapter will continue to monitor the service as it expands. The inadequacy of emergency services after hours and on weekends surfaced when new commitment laws were passed and citizens requiring initial assessments had to be transported by the sheriff's department 20 miles to the emergency service unit at the second center. The result was that patients were detained for hours awaiting evaluation and proper disposition. The MHA maintained that though the service was available, it did not adequately meet standards for accessibility.

LEVEL OF PARTICIPATION

The High Point Mental Health Association was involved in each phase of the initiation, surveys, and implementation of a model for expansion of emergency services. MHA members initiated and participated in a United Way survey to document need, wrote letters to county commissioners in support of the model, and continually raised the issue to keep it visible to mental health officials. The pressure kept up until there was sufficient support from authorities to implement the plan that the local director proposed and the association supported.

TARGET OF EVALUATION OR MONITORING

The agencies studied were the Guildford County Mental Health Center and local division of the mental health center; and the specific program studied was emergency services. According to the 1980 census, Greensboro has a population of 155,642 and High Point 64,107 for a combined city population of 219,749. County residents outside each city are included in the catchment area and the total population in Guilford County is 317,154. After-hours emergency services were primarily provided by the county emergency unit. There was no local psychiatrist in private practice; a psychiatric nurse consulted with local physicians to facilitate private emergency evaluations.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

This monitoring encountered a number of related problems--inaccessibility, delays in evaluation and treatment, transportation problems to emergency services and to the hospital, reluctance of magistrates to issue a commitment petition, and reluctance of emergency room physicians to either initiate a petition or complete the first medical evaluation recommending commitment.

TECHNIQUES USED

Interviews were conducted with: magistrates; selected patients who had used emergency services and who were in the socialization program operated by the association; the director of the outpatient and emergency departments of the local hospital; local police; school counselors; clergy; and local physicians. The purpose of the interviews was to determine local and area responsiveness and document problems in delivery of emergency services after hours. Local and county emergency service staff were interviewed during the State onsite visit.

FINDINGS OF EVALUATION OR MONITORING

Board members were pleased with reports from

the above-mentioned referral sources, which substantiated that local emergency services were responsive and effective during hours, and that the difficulties lay in getting local patients to the after-hours emergency service 20 miles away.

RECOMMENDATIONS

Based on the two surveys of needs and on interviews, the MHA board recommended that an alternative plan to expand emergency coverage in High Point be developed, and that statistical information about after-hours contact and systematic followup be instituted.

STEPS TO ENSURE IMPLEMENTATION

The local center director was already eager to expand emergency coverage. Once the issue was identified and recorded in the onsite review, and letters of support were received by the county commissioners, the local director had the backing needed to present a model for expansion to the area board and commissioners in order to secure funding for a modest beginning toward expansion. Progress was monitored through MHA representation on the area board and through frequent contact with the center director.

EXTENT OF IMPLEMENTATION

The center is currently negotiating with two nurses who will be employed for after-hours coverage with backup from the local center psychiatrist. This nurse will provide liaison between the mental health center and the hospital, and will conduct evaluations in the emergency room. After consulting with the oncall psychiatrist, the nurse will direct the patient to the proper agency which will then coordinate and expedite further treatment in an appropriate and timely fashion.

SPECIAL BARRIERS OR SUPPORTS

The local center director and emergency services staff were very supportive of MHA's project and helped direct its members through the steps necessary to attain approval. Barriers included budget cuts that severely limited funds for expansion and the desire of area program staff to contain after-hours services in the adjacent city.

RESOURCES AND COSTS

United Way absorbed the costs and provided volunteers for their study. Individuals from the association contributed their time and expenses related to their documentation efforts. The local center provided clerical and technical assistance for their study and the resulting model for expansion. The association did not have to allocate money from its budget.

ADDITIONAL COMMENTS

Although this project represents a lengthy process, it was facilitated by the board's persistence and the local director's expertise and commitment. The alliance between the center and the association and the dedication to this project were very effective in working through resistance and generating a creative model for expansion of a vital service during a time of severe budgetary cuts. Furthermore, an essential element was the careful identification of the political elements in the environment of a center that had to be attended to.

How Will You Go About It?

Having defined their problem and specified a series of research questions that warrant further investigation, Doug Brown now has to identify a strategy for answering these questions. At least three factors have to be considered by the committee before they can select a methodology. The first is the nature of the committee's authority with the mental health system. Groups that have formal authority over facilities within the system clearly have more latitude regarding the types of demands for data that they can make. Those without a formal mandate have to rely on the voluntary cooperation of agencies or, failing this, collect data that are not dependent on agency cooperation (e.g., information that is part of the public record or information from key informants who are not affiliated with the agency or agencies being evaluated).

The second factor that will constrain Doug Brown's choice of a method is, of course, the nature of the problem being evaluated. Those problems that are very narrow and clearly defined frequently can be addressed with a single approach. For example, client satisfaction with services can generally be assessed adequately with a client survey, and the issue of staff morale can be evaluated with a survey of personnel attitudes. Doug Brown's problem, however, is quite broad and touches on a variety of different issues. His group, therefore, will have to design a strategy that includes a number of different approaches or methods.

The third consideration that will constrain the group's choice of a methodology is the level of resources at the committee's disposal. Such resources include funding, availability of data, expertise of committee members, availability of outside expertise, and the amount of time that committee members can afford to donate to the project. If these factors are not accurately assessed, the group runs the risk of beginning an overly ambitious project that they may be unable to complete.

Having considered the various research methods available to them, Doug Brown's committee selects a methodological approach that will allow it to explore several aspects of the problem and that will make full use of available resources. Since the decision to close a wing of the Riverview State Hospital has been a controversial one within the community, the committee decides to begin with a limited number of public forums in which citizens, as well as mental health professionals, will have an opportunity to make their opinions known.

Secondly, the committee plans to use data that have already been collected by the State and county departments of mental health. Typically, mental health departments have some information on the characteristics of clients residing in State institutions and on the number and types of providers within the community. These data will allow the committee to assess the match between the needs of the clients who are to be discharged to the community and the services that are available in the community. In the present case, the committee is fortunate in having a relationship with a local community college and will be able to rely on some student and professional assistance in analyzing these data.

Recognizing the wealth of professional expertise and knowledge about this community's needs and resources among local service providers, the committee decides to augment their data collection efforts by interviewing knowledgeable providers. Finally, one member of the evaluation committee who is a certified public accountant will examine available data on the costs of providing services to clients in the institution and in the community.

The committee recognizes that this is a very full research agenda and has allocated a full year to completing the various components.

The cases in this section illustrate a variety of different research methods that can be used by citizens in evaluating or monitoring mental health services. In many instances, those methods can be carried out without a great deal of technical assistance, and none of the methods illustrated here requires a substantial budget.

Site Visits and Key Informant Interviews

The approach that is described most frequently in other chapters of the **Casebook** is a combination of site visits and interviews. Some evaluators conducted site visits only. Typically in these cases the evaluators visited programs using some form of checklist. They observed the agency's operations and physical facilities and recorded scores within predetermined categories. In other cases the evaluators combined the observational data with data obtained from interviews with staff and/or clients.

Secondary Data Analysis

The first case included in this chapter, reported by Frances P. Meehan and John J. McDonough, is an example of a secondary data analysis technique. In this case, members of the Los Angeles County Mental Health Advisory Board were attempting to put pressure on the county administration to appoint a permanent director of mental health. In order to buttress their arguments, members of the advisory board obtained and reviewed data collected by the county. They used salary data and information contained in auditors' reports to the State. In addition, advisory board members also conducted interviews with a number of individuals in key administrative positions. The combination of secondary data analysis and key informant interviews is an effective approach that is used frequently in evaluation research.

Case Simulation

The second case is described by Aldene Hart and Barbara Goza. In this case, members of a citizens' advisory council evaluated a community mental health center's crisis services through a case simulation technique. Three advisory council members placed a series of afterhours telephone calls to the center's crisis unit posing as clients in need of assistance. Crisis service staff were unaware of the research project until the study was completed. This case represents a study that was well designed and carefully executed. The data collected were appropriate given the questions that the citizens wanted to address. However, such clandestine methods should be used cautiously. Had the results shown the service to be poor, the secretive nature of the research methods could have had negative repercussions on the board's relationship with center staff. This is not to say that such measures should not be used--only that the potential value of the information obtained should be carefully weighed against possible negative fallout.

Clinician Interviews

In the third case, reported by Elizabeth Fulton and Bruce Hirsch, members of a mental health association were interested in exploring the match between the needs of clients being referred from the area's psychiatric emergency services and the services that were available in the community. To address this question, members conducted a series of interviews with referring clinicians in the psychiatric emergency service units. Prior to the actual data collection, the volunteers met with the directors of each psychiatric emergency service and visited the facility during daytime and evening hours. As a result, they were well aware of how the units operated and were able to design an interview schedule that focused on relevant issues. This type of preparatory effort is crucial in designing useful survey forms. It should be noted that this interview method can also be used to collect data from other types of mental health providers, clients, clients' families, etc.

Structured Group Approaches

The next two cases in this section utilize structured group approaches. In one, Myrtle C. Nash and Sharon F. Bock describe the use of the "nominal group approach" in a needs assessment study. For this study, members of the program evaluation committee assembled four groups of citizens representing consumers, civic leaders, mental health professionals, and business and industry. Members of each group were asked to identify unmet service needs in the community. The nominal group approach is a method that attempts to obtain maximum participation from all group members by focusing their attention on clearly defined issues and soliciting the ideas of each member in a structured fashion. Kate H. Lothrop and Barbara Whetstone describe the use of a similar method, the Delbecq Nominal Group Technique, in their account of a study examining the issue of no-shows in a community mental health center. These methods are useful because they allow researchers to obtain feedback from a variety of sources in a very efficient manner.

The case described by Hays and Whetstone also illustrates the use of a citizen review group. The 1975 Amendments to the Community Mental Health Centers Act mandated that citizens be involved in reviewing CMHC evaluations. Joan Zinober and Nancy Dinkel (1981) attempted to formalize this process through a research project funded by the National Institute of Mental Health. The project resulted in a manual that describes the process of developing citizen review groups for the purpose of reviewing agency evaluations

and making recommendations based on these secondary data analyses.

Use of Standardized Instruments

Rick Kastner and Marilyn Lee Olds describe a more standardized technique in their account of the Lancaster County Mental Health/Mental Retardation Board's use of PASS--Program Analysis of Service Systems. PASS is a method developed by Wolf Wolfensberger and Linda Glenn (1975) for evaluating residential programs for developmentally disabled persons. The method involves the use of structured interviews and checklist forms that cover program administration, fiscal matters, programmatic issues, and the physical and social environments of programs. This program is quite comprehensive and, since it involves the use of standardized instruments, researchers can compare their findings with published data on similar programs. This is certainly a useful attribute. Potential users of PASS, however, should be aware that the instrument is based on the ideological principle of normalization. It confers higher scores on those programs that come closest to approximating a normal community environment for clients. For those programs that do not share this commitment, another instrument might be more relevant.

Evaluability

The next case in this section is an example of an evaluability study. Vera Mellen describes a board of directors' effort to conduct a client outcome study. The citizens involved in this project began what they thought was to be a fairly straightforward outcome study and found that the data they needed were unavailable. In the end, they performed what was essentially an evaluability study, laying the groundwork for further research by specifying the data that would be necessary to conduct an adequate exploration of client outcomes. Evaluability studies are small studies that are conducted prior to large-scale evaluations. The objective is to assess the adequacy of available data and the overall feasibility of launching the larger evaluation. An evaluability study can be quite cost effective in those instances where the usefulness of existing information is doubtful.

Freedom of Information

The final case in this section is quite different from the preceding cases. In this report, Richard Hessler and Michael Walters describe a citizen group's attempts to obtain copies of NIMH reports concerning a local mental health center. The group felt that the data in these reports were crucial for their own study of followup services for adult patients discharged to the community. The group requested the data from NIMH, the NIMH regional office, the State division of mental health, and the center itself. Their initial attempts met with failure since these reports were exempt from the mandatory disclosure provisions of the Public Information Act. Eventually the group contacted the assistant chief of the Legislative Services Branch of NIMH requesting a formal amendment to the Public Information regulations that would give citizen groups access to NIMH reports of site visits to mental health centers. The case was reviewed by the DHHS Freedom of Information Officer. Ultimately, the citizen group obtained the reports they were seeking and also succeeded in having the regulation changed so that other citizen groups would be guaranteed access to this information. The case clearly illustrates the power that well-organized citizen groups can have.

Additional Methods

A number of cases that appear in other chapters of the *Casebook* illustrate additional methods that citizens might use. One innovative strategy is the use of computer modeling for resource allocation (case #31). Another method is record review in which the evaluators examine client records to extract the relevant information on clients (cases #20, #34, and #49). Client data can also be collected through interviews with clients as illustrated in cases #8, #9, #12, and #35. Finally, cases #7 and #18 illustrate the use of public forums for gaining data and ideas from a wide cross-section of the community.

These cases illustrate the variety of methods available to citizens. The methods discussed, however, are hardly exhaustive. Readers who desire more detailed descriptions of the methods described here or other methods that can be used should refer to: *Citizen Evaluation of Mental Health Services*, by Val. D. MacMurray et al. (1976); *Evaluation in Practice: A Sourcebook of Program Evaluation Studies for Mental Health Care Systems in the United States*, edited by Gerald Landsberg et al. (1979); and *A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers*, by Homer J. Hagedorn et al. (1976).

44. A Mental Health Advisory Board's Use of Secondary Data Analysis Techniques

Frances P. Meehan and John J. McDonough

Los Angeles County Mental Health Advisory Board

SUMMARY

In 1977, mental health services in Los Angeles County were provided by the department of health services. After extensive effort by the mental health advisory board, the Los Angeles County board of supervisors was persuaded to separate the department of mental health from the department of health services. The board of supervisors appointed a new director in order to establish adequate levels of accountability for the county's mental health programs.

TYPE OF ORGANIZATION

Under California law, the mental health advisory board is appointed by the Los Angeles board of supervisors to advise the board of supervisors and the director of mental health services. All members serve in the public interest and may not be employees of the county mental health department or of the agencies receiving Short-Doyle funds. The board must represent psychiatry, psychology, psychiatric nursing, psychiatric technicians, social work, the county supervisors, and the general public.

EVALUATORS OR MONITORS

The mental health advisory board was composed of a psychiatrist, another physician, a psychiatric technician, a nurse, a social worker, a psychologist, a County Supervisor, and eight additional members representing the general public.

REASONS FOR THE EVALUATION OR MONITORING

In 1974 the department of mental health had been merged with three other county departments to form a department of health services.

A general hiring freeze within the county was extended to personnel paid out of Short-Doyle funds, despite the fact that the State had already allocated these funds to the county. Requests went unheeded to the interim acting deputy director of the department of mental health, to the director of health services, and to the director of the department of personnel for hiring replacements with available Short-Doyle money. The result was that mental health programs were unable to spend the dollars allocated by the State and the county was able to divert the "savings" into other programs.

The need was acute for an extremely competent, permanent director for mental health services.

LEVEL OF PARTICIPATION

The Los Angeles County mental health advisory board, a citizen group, became actively involved in the attempt to improve accountability and responsiveness within the mental health advisory system. These actions were independent of any government entity.

TARGET OF EVALUATION OR MONITORING

The focus of the board's efforts was the Los Angeles mental health program. The Short-Boyle mental health services program was located within the Los Angeles County department of health services. The director of health services was appointed by the board of supervisors as the local director of mental health services. Medical responsibility was delegated to the deputy medical director of mental health services.

Los Angeles County has a population of more than seven million persons spread across a great diversity of communities and geographical areas.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The problems addressed by the advisory board were:

- The need to establish clear channels of accountability for the effective delivery of county mental health programs
- The need for information regarding the gross "savings" associated with the county mental health freeze in 1976-77 and the net "savings," an explanation for the deterioration of services despite a substantial increase in funding and a detailed breakdown of central office costs
- The need for a commitment that mandated Short-Doyle programs would not be seriously impeded by the county personnel freeze

For further information write Frances P. Meehan, Ph.D., 460 W. Walnut Ave., Arcadia, California 91006, (213) 446-4062.

- The need to give top priority to recruiting and selecting a permanent deputy director for mental health services and to upgrading the position

TECHNIQUES USED

Members of the advisory board regularly attended the weekly policy meeting of the top mental health administrative staff and reviewed auditors' reports to the State. A member of the board requested salary data from regional directors. Interviews were held with the director of health services, the interim deputy director of mental health, program managers, regional directors, and the director of the department of personnel.

FINDINGS OF EVALUATION OR MONITORING

After reviewing available data and conducting numerous key informant interviews, members of the advisory board concluded that there was a need to separate the department of mental health from the department of health services. They also concluded that Los Angeles County had tried to save money by retaining a temporary interim deputy director of mental health who was unable to cope with extremely serious problems and that Short-Doyle money was being diverted from mental health to other needs of the department of health services. The accountability of the board of supervisors was challenged.

RECOMMENDATIONS

In 1977, the total funds expended on Short-Doyle programs for Los Angeles County was $130 million with 90 percent provided by the State and a 10 percent match by the county. The Los Angeles mental health advisory board by law had the power to approve the planning process and to make recommendations as to specific items in the plan. In June 1977, the Los Angeles County mental health advisory board unanimously decided that they would approve the planning process only if the department of health services met a set of conditions specified by the board. The conditions included:

1. Convening a "summit" meeting with county department of health personnel, representatives from the board of supervisors and the mental health advisory board in order to clarify accountability with respect to the delivery of mental health services

2. Providing the mental health advisory board with information on:

- The gross savings associated with the 1976-77 personnel hiring freeze, the net savings resulting from the freeze, and an explanation of the discrepancies between these two figures

- An assessment of the reliability of data indicating a serious deterioration in the provision of services despite increased funding and a plan for improving the information system

- A break down of the $6.6 million central office costs including separate accounting for each major program element

3. Changes in organizational structure and priorities including:

- Assigning top priority to recruiting and selecting a permanent deputy director for mental health services

- Upgrading the role of the deputy director within the department

- Upgrading the role of the regional mental health chiefs to include regional planning and policy formulation and clarifying the relationship between the regional chiefs and the department mental health chief

STEPS TO ENSURE IMPLEMENTATION

By a unanimous vote, the mental health advisory board refused to approve the 1977-78 Short-Doyle planning process for mental health services beyond a conditional 90-day period (from the date of the approval of the board of supervisors). State funding is not forthcoming for mental health services without the advisory board's approval.

EXTENT OF IMPLEMENTATION

Following the mental health advisory board's report, a number of activities was initiated. The department of mental health was separated from the department of health services. A search for a permanent director of the department of mental health was initiated. Such changes have led to a more effective administration of mental health and increased respect for the mental health advisory board.

SPECIAL BARRIERS OR SUPPORTS

The administration of the health department was unresponsive to requests for information. Tracking expenditures through the maze of the health department budget was difficult. Regional deputy directors of mental health programs cooperated with the efforts by the mental health advisory board. They were willing to answer specific questions about expenditures to a citizen member of the advisory board. The mental health

advisory board members worked well together and persisted until all changes were made.

RESOURCES AND COSTS

Some mental health advisory board members donated several hours per week over a period of several months. Each member spent at least several hours per month. All time and out-of-pocket expenses were donated. The executive assistant assigned by the department provided technical assistance.

ADDITIONAL COMMENTS

Our advisory board simply got tired of being a "rubber stamp" for decisions already made by health department bureaucrats who had no real interest in, or knowledge of, mental health problems within the county. We took a stand and made a vow to either get results or to resign. We found the perfect vehicle. We were able to use our power of approval over the planning process to virtually stop the flow of State money and to get some action from the county.

The power we had went beyond fiscal power. We discovered we had the ability to use planning authority to take important issues of mental health programs, effectiveness, and accountability to the public and the media.

In hindsight, we were fortunate to get everything we asked for and, at the same time, to enhance our standing with the county board of supervisors. The board of supervisors had taken an active role and has been interested in the mental health program ever since.

You cannot underestimate the power citizens have in addressing program deficiencies and organizational problems. Citizen volunteers' independence and credibility have the potential for a great impact on the issues.

45. Citizens' Advisory Council Uses Case Simulation Technique to Evaluate Crisis Services

Aldene Hart

Granite Community Mental Health Center Citizens' Advisory Council

Barbara K. Goza

Salt Lake County Division of Mental Health

SUMMARY

In response to a National Council of Community Mental Health Centers (NCCMHC) survey suggesting deficiencies in CMHC crisis services, the citizens' advisory council conducted a study of Granite Community Mental Health Center (GCMHC) crisis services. Three council members made 25 after-hours calls to the center's crisis service during a 3-week period. Fictitious names and vignettes were used, and the staff were not informed of the study until data collection was completed. The advisory council expected to find the GCMHC crisis service working pretty well, and were not greatly surprised by the study's positive findings. The answering service response was quick and courteous and the crisis workers' responses were equally quick.

TYPE OF ORGANIZATION

The evaluation was conducted by the citizen's advisory council for the community mental health center, in collaboration with center staff and management. The 20-person council was composed of interested community members appointed by the council with the approval of the county commission that serves as the governing board of the center. The advisory council considers itself an advocacy group--both for the center and for the community it serves. Membership on the council is determined by professional skills, special interests such as service consumer or minority representation, or general interest in mental health issues.

EVALUATORS OR MONITORS

The three advisory council members who performed this evaluation were lay persons. However, they did receive some consultation from the research and evaluation staff of GCMHC.

REASONS FOR THE EVALUATION OR MONITORING

The findings of a National Council of Community Mental Health Centers survey suggested that CMHC crisis services in general were not as

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effective as the community needed. The NIMH study had telephoned crisis numbers and found that one-third did not answer. In addition, there had been criticism of local crisis services. The director of GCMHC provided the advisory council with this information and the advisory council initiated the reported research in their role as program advocates. Many of the advisory council members had been on the crisis service team and were concerned about the way these services were being evaluated externally. They also felt that negative findings about GCMHC were unlikely in view of their experience.

LEVEL OF PARTICIPATION

The advisory council was totally responsible for the conduct of this research. They initiated the research, informing only the center director, adult and family unit director, and crisis service coordinator. The research staff provided some consultation in the design of the research and in analyzing the data.

TARGET OF EVALUATION OR MONITORING

Granite Community Mental Health Center's crisis service uses trained volunteers (all with professional backup) or mental health personnel in its after-hours crisis service. The crisis service is under the administrative supervision of the adult and family outpatient services at GCMHC, and is supervised by a crisis service coordinator.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The question to be answered by this research was: how accessible is GCMHC crisis service to individuals requesting services after normal working hours?

TECHNIQUES USED

In a 3-week period 25 after-hour calls were made to GCMHC crisis service. Except for several times specially chosen as the hardest times to get service (weekends or shortly before or after working hours), all call days and times were randomly chosen. The study team designed vignettes based on their crisis experienced at GCMHC and another local agency. When the answering service operator answered the phone, the researchers gave the operator a fictitious name, presented a problem, and asked to speak to a crisis worker. Typical crisis vignettes were:

- My daughter is talking about suicide.
- The police are looking for my daughter and I would like her taken to the mental hospital rather than to the detention center.
- I have to have some help because I'm afraid I'm going to hurt my little girl.
- My husband just walked out on me.

After the researcher spoke with the crisis worker, the worker was thanked, the study was explained, and the worker was asked to keep the study confidential. Data collected included the number of rings required to reach the answering service and the number of minutes to reach the crisis worker.

FINDINGS OF EVALUATION OR MONITORING

The answering service response was quick and courteous. The phone rang more than 6 times only once (41 rings), and the average number of rings was 4.1 (median, 2.5). In only one case did the researcher consider that the answering service response might have been more caring: a 7:45 a.m. call was responded to by asking the caller to wait a few minutes and call the center. It was also discovered that the 41-ring call was probably due to a structural problem. The center had only two lines at the answering service, and when they were both busy, the line kept on ringing.

The crisis workers' responses were equally quick. On 87 percent of the calls, the researcher was held on the line and then connected directly with the crisis worker. If the time on hold was more than a couple of minutes, the answering service operator checked back to reassure the "crisis case." The average amount of time until the researcher reached a crisis worker was 4.4 minutes (median, 1 minute). In 56.5 percent of the calls, the wait was 1 minute or less. The wait was longer than 10 minutes in only two cases. One call did not result in a crisis worker contact. Later investigation found that the crisis worker was given the wrong number by the answering service. Advisory council members also reported their qualitative impressions of the crisis service.

RECOMMENDATIONS

The findings and recommendations of the advisory council study were reviewed by the center executive committee and were provided to NIMH at their yearly site visit, and to the national council offices. The major recommendation was that the Granite CMHC staff and answering service should be rewarded for their high-quality crisis service. The qualitative and quantitative data led the researchers to conclude: "We feel very strongly that this is exceptional work and shows the quality of Granite's crisis service. We also would like to commend the crisis staff and the center for their openness to evaluation, their lack of defensiveness, and their understanding about being awakened at 5 o'clock in the morning."

It was suggested that the answering service be

counseled about the importance of double-checking phone numbers to ensure their accuracy, and that a busy signal be arranged to indicate that both lines were busy. These suggestions were implemented.

STEPS TO ENSURE IMPLEMENTATION

The research team was particularly concerned with maintaining the objectivity of the study. In order to maintain this objectivity, crisis service staff were not informed of the research. The only staff members who knew about the research were the center director, the adult and family services director, the crisis service coordinator, and a research and evaluation design consultant. As crisis workers were informed of the study and its purposes, they were asked to maintain the confidentiality of the research. This confidence was maintained.

EXTENT OF IMPLEMENTATION

The advisory council felt that all recommendations had been implemented.

SPECIAL BARRIERS OR SUPPORTS

The research team considered the most important element supporting utilization of the research to be the upfront preparation to maintain the quality of the research itself. Several preparatory meetings were held to ensure the plausibility of crisis vignettes, to create a broad range of crisis problems in the vignettes, and to ensure random selection of times for the crisis calls. Management was also extremely supportive of the research, and was willing to maintain the secrecy of the design.

RESOURCES AND COSTS

The amount of time required to perform the evaluation totaled 199 hours. The breakdown of hours were: advisory council members, 100 hours; research staff, 75 hours; crisis and adult and family directors, 4 hours; crisis workers (as subjects), 20 hours.

ADDITIONAL COMMENTS

The advisory council was very impressed with the crisis system, and with management's responsiveness to suggested changes. They did not feel that they would change any aspect of the research. Their primary lesson from performing this evaluation is: preparation pays.

46. Mental Health Association Evaluation Using Interviews with Clinicians

Elizabeth Fulton and Bruce Hirsch

Mental Health Association of San Francisco

SUMMARY

This study of crisis services was conducted by volunteers from the Mental Health Association of San Francisco (MHASF), a volunteer nonprofit organization. The project grew out of a preliminary study of the psychiatric emergency services (PES) at two major San Francisco hospitals. The purpose of the crisis study was to assess the availability and appropriateness of followup treatment services for people who experience psychiatric crises and enter the system through PES. It sought to find out if there is a match between the clinicians' recommendations for care and available services. Where such a match did not exist, it attempted to identify the problems.

TYPE OF ORGANIZATION

The Mental Health Association of San Francisco is a nongovernmental, nonprofit volunteer organization affiliated with the Mental Health Association of California and the National Mental Health Association. It advocates for improved mental health services and seeks to educate the public about mental health and mental illness. Its 800 members reflect the cultural diversity of the San Francisco community. The association is governed by a board of directors elected from the membership.

EVALUATORS OR MONITORS

This study was carried out by the public affairs committee of MHASF in cooperation with the directors of the psychiatric emergency service units being studied. The committee organized a group of 25 volunteers to conduct the study. The volunteers included students, housewives, and representatives from a variety of occupations. MHASF staff provided support to the volunteers.

REASONS FOR THE EVALUATION OR MONITORING

The project grew out of a preliminary study of

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the psychiatric emergency services at two major San Francisco hospitals. For many people, PES is the entry point to community mental health services programs. The preliminary study familiarized volunteers with PES facilities through site visits and identified the need for a study of the followup treatment services available to people who enter the mental health system through PES. The aim of the crisis study was to determine whether needed followup services were available in the community.

LEVEL OF PARTICIPATION

Before the data collection began, the public affairs committee drew up a formal research proposal that was approved by the department of public health. The 25 mental health association volunteers conducted 130 hours of interviews with clinicians. Each of the volunteers attended a 3-hour orientation session and a 3-hour debriefing session. Mental health association staff provided support to volunteers as part of the ongoing public affairs program. Volunteers worked with PES directors to draw up a questionnaire that measured the appropriateness of referrals as assessed by the referring clinician.

TARGET OF EVALUATION OR MONITORING

The study involved two PES units that are part of community mental health services in the city and county of San Francisco. The facilities are the San Francisco General Hospital PES and the Westside Crisis Clinic at Mt. Zion Hospital. San Francisco General Hospital is located in an ethnic low-income area. It covers two catchment areas and handles overflow from other districts. The predominant groups using services of this crisis unit are white, black, Hispanic and Chinese. The facility is open 24 hours a day and handles 500 to 800 patients a month for formal evaluations. The patients present problems across a wide range of crisis and dysfunctional states. The majority of patients are from the chronic psychiatric population and are diagnosed as psychotic or borderline psychotic. Most patients stay at this PES from 1¼ to 5 hours. Inpatient referrals are to two inpatient psychiatric wards, the forensic unit of the medical/psychiatric jail ward at San Francisco General Hospital itself, private psychiatric wards at five other hospitals, or to the State mental hospital in Napa. The hospital has a transitional extended emergency service program for repeat users who do not follow through on community referrals.

Westside Crisis Clinic is located in a predominantly low-income area, although its catchment area includes some high-income sections. Major client groups are black, white, Chinese and Philippine. Westside serves one catchment area through the community mental health services program. It operates 24 hours a day and handles about 500 patients a month. The bulk of patients seen are chronically mentally ill. Many patients are in a life crisis or are experiencing a combination of acute family, drinking and drug problems. The length of stay is from 1 hour to 3 days. Inpatient referrals are made to private psychiatric hospitals; State hospitalization is avoided where possible. Westside Crisis Clinic has a medication clinic for outpatients who do not follow through on referrals to community resources.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

PES is the entry point to the San Francisco public mental health treatment system for many people experiencing a psychiatric crisis. The study sought to find out if there is a match between clinicians' recommendations for care and available services. Where such a match did not exist, the study attempted to identify factors that interfere with the referral process. Some of the factors examined were the type of diagnosis, whether the facility to which the referral was being made was at maximum capacity, and the degree to which regulations such as geographic districting limit the availability of services. The study examined how often each patient had been seen in the crisis unit, and compared the referring clinicians' preferences in terms of followup services with what services, if any, were available in the community.

TECHNIQUES USED

Volunteers met first with the administrators of each PES to become familiar with the operation of the units. They then visited the facilities as teams during key hours of the day and night. This experience gave volunteers some idea of the problems regularly encountered in the crisis units.

With the aid of the PES directors, volunteers designed interview forms for clinicians that included demographic data for each clinician including: ethnic group, language capabilities, age, sex, professional training, amount of professional experience, and length of time at PES. Questions regarding diagnosis, the appropriateness and availability of followup services, and other factors influencing referrals were also included.

The method used in this study was to interview clinicians in the crisis units after the clinicians had evaluated clients. There was no direct contact between volunteers and clients, and demographic information on clients was coded for hospital staff access only.

Clinical diagnosis and a DSM III (Diagnostic Statistical Manual) code were entered on the interview forms. This permitted subsequent assessment of clinician attitudes toward availability of services for clients with similar diagnoses.

During one week, 25 volunteers spent 1,300 hours interviewing clinicians to compile the data for the final report. Originally the data were to be analyzed manually, but the complexity of the study necessitated computer assistance.

FINDINGS OF EVALUATION OR MONITORING

The study uncovered a complex set of issues ranging from initial diagnosis to referral. Some of these had to do with the availability of services for referrals, and the difference between the actual referral made and the clinician's determination of the ideal referral. In addition, some political, economic, and social constraints on the use of the appropriate referrals become apparent. The complexity of these issues required the assistance of specialists who are now conducting further computer-assisted data analyses in order to compile more specific findings.

RECOMMENDATIONS

The final report on the study is not available yet. Recommendations that have been made to date concern additional analyses to be conducted. The analysis will be a collaborative effort between the mental health association and specialists in research methods and statistical techniques. Specific issues being analyzed are: (1) diagnosis and clinician's confidence in the diagnosis; (2) contributing problems and secondary diagnosis; (3) ideal disposition for the patient; (4) whether the required services exist and whether the patient was sent to that services; (5) why some patients were not sent to services that were available; (6) the clinician's evaluation of the actual referral as opposed to the ideal one; (7) how the referral was made; and (8) how many times the patient had been seen in the unit in the last 6 months.

The University of California at San Francisco found the preliminary data interesting enough to provide a small biomedical support grant to the director of one PES. Further analysis of the data is now underway at the university.

STEPS TO ENSURE IMPLEMENTATION

The project is not yet completed and, therefore, the implementation plan has not been finalized.

SPECIAL BARRIERS OR SUPPORTS

Initially, the clinical staff at the crisis units had reservations about the presence of volunteers in the units, since some volunteers were unfamiliar with the realities of PES work. However, the volunteers were sensitive to the needs of staff and to the necessity for evaluating what took place without interfering. In the end, the process was one of mutual education for volunteers and staff alike. The orientation for volunteers, led by PES officials, was very important in building bridges between the two groups. PES directors were particularly instrumental in making the volunteers feel welcome.

RESOURCES AND COSTS

Hospital visits were conducted by 25 volunteers over a period of 7 days, totaling 130 hours of observation and interviews. Volunteers were supported by mental health association staff as part of the MHA's ongoing public affairs program.

ADDITIONAL COMMENTS

The study gave volunteers an opportunity to understand the central place occupied by PES units in community mental health services. Since PES units are often the first contact patients have with the system, the appropriateness of followup services is an important subject of investigation for professionals and volunteers alike.

The volunteers were impressed with the personal and professional dedication of clinicians in the PES. They also felt that since their study obtained information never available before, it would increase the ability of the crisis units to serve people entering the treatment system through these facilities.

47. Citizens Participate in a Nominal Group Approach to Identify Needs

Myrtle C. Nash and Sharon F. Bock

Spartanburg Area Mental Health Center

SUMMARY

The Spartanburg Area Mental Health Center's (SAMHC) program evaluation committee (PEC) conducted a key informant needs assessment survey utilizing the "Nominal Group Approach." Citizens who were knowledgeable about the community were asked to identify the area's most pressing unmet needs. Four separate workshops were convened for: (1) agency representatives, (2) spokesmen for the minority community, (3) representatives from industry, and (4) clients.

TYPE OF ORGANIZATION

Evaluation activities for the center are the responsibility of the program evaluation committee (PEC), established as part of an ongoing quality assurance program during the late 1970s. It is a multidisciplinary committee, composed of center staff members appointed by the program director with the advice and consent of the medical director. The committee is responsible for all evaluation activities required by Federal and State funding sources including needs assessments, consumer satisfaction surveys, biometry and epidemiology reports, and various service component evaluations. It also functions as a resource to individual program managers who wish to undertake service element evaluations not necessarily required by external sources. Finally, the committee is responsible for overseeing the management of patient and fiscal data.

The committee is accountable to the program director and the medical director and routinely reports evaluation activities to them. Required Federal and State reports are a matter of public record and are included in the SAMHC's annual report.

EVALUATORS OR MONITORS

This study was conducted by SAMHC staff using citizens as key informants. The citizens who participated in the evaluation were chosen to represent different points of view. There were professionals (agency representatives), clients, civic leaders (spokesmen for the minority community), and representative from business and industry. The separate groups were selected with the expectation that each would tend to perceive the functions required of the center somewhat differently. We anticipated a wide range of views about how our agency is perceived in the community and which needs it is failing to meet.

REASONS FOR THE EVALUATION OR MONITORING

The State office requires an annual needs assessment. The evaluation team recognized the value of assessing a broad spectrum of the community, but resource limitations precluded the design of a comprehensive evaluation tool and administration to a large sample; hence, the Nominal Group Approach was chosen as an alternative model that would provide information in an efficient manner. The Nominal Group Approach provided the center evaluators with data and suggestions from a cross section of citizens and was undertaken with a minimum expenditure of staff time and effort.

LEVEL OF PARTICIPATION

The PEC was solely responsible for the development and implementation of the needs assessment project. Committee members selected the Nominal Group Approach, developed questions to be answered by participants and collected lists of citizens who would be representative of various target groups. With assistance from other staff members, the PEC conducted the needs assessment meetings. Each of the citizen participants attended one 3-hour workshop. The committee then compiled and analyzed the information and developed summaries for presentation to the center executive committee, the total staff, and the board of directors, and for inclusion in the SAMHC annual evaluation report for 1979-80. The letter of thanks that went to each participant also included a summary of results.

TARGET OF EVALUATION OR MONITORING

The study was limited to Spartanburg County, one of the counties served by the Spartanburg Area Mental Health Center in Spartanburg, South Carolina. SAMHC is a comprehensive mental health center and provides the twelve services

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that were mandated by law at the time of this study. It has a psychiatric director, a program director, and an administrator or business manager. Each service has a coordinator. These coordinators, the three executives mentioned, and the administrative assistant to the business manager constitute the executive committee.

The city of Spartanburg is a highly industrialized community in a rural county. Spartanburg started as a cotton mill town that now has widely diversified, mostly light industry. In the past, Spartanburg has sent a disproportionately large number of people to the State hospital. There has been speculation that conditions in industrial plants might be a relevant factor. The estimated population of the city of Spartanburg is 43,000; that of the county is 197,000.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

This evaluation focused on the quality of service. Three questions were formulated for use in the workshops: (1) "What are the most serious unmet needs for mental health services in the community?"; (2) "What is the most serious barrier to getting help at the mental health center?"; (3) "What stories have you heard about the center which might make it hard for some people to come here?" It turned out that only the first question could be thoroughly analyzed by the Nominal Group Method in the 3-hour workshop.

TECHNIQUES USED

The Nominal Group Method was suggested by the chairman of the evaluation committee, selected by the committee, and approved by the executive committee of the center. It was decided to use four sessions, each one for a different group of informants.

Potential participants were identified by center staff. Letters of invitation were drafted and modified slightly for each of the four groups. The invitation described the goal of the project, outlined particulars of the workshop, and encouraged participation.

The actual conduct of the workshops is of some interest. After all participants had been welcomed individually and then collectively by the center director or program director, the coordinator of the workshop briefly outlined the workshop goals and reviewed the format to be used. Participants were then asked to break into small groups. The individual's group was designated by a color on each name tag. The question to be addressed was on the blackboard.

Each participant was asked to write down as many responses to the question as he/she could think of during a 10-minute period. Then the staff member began with one person and asked the person for one item from his/her list. The recorder wrote the item on a tablet on the wall. The next person was asked to contribute an item from his/her list. This sequence went on until everybody had a chance to contribute an item. Each group member was then asked to indicate which of the items listed on the tablet were also on their individual lists. A check mark was put on the item each time it was mentioned. Listing continued until all items from the lists were recorded and tallied. Ten minutes for discussion and clarification followed. Then a new sheet of paper was started to indicate combinations of items and relationships.

After all possible combinations were listed, the participants were given a few minutes to select the top five priorities and write them down individually. Then a vote was taken and the number of votes for each item entered on the list. Next a priorities list was made containing the five items receiving the most votes.

After a short break, the workshop members worked together and the final list of priorities for the question was established.

FINDINGS OF EVALUATION OR MONITORING

Essentially, we found that the greatest perceived need for mental services was for public information about mental health and about the center. There was considerable agreement about this from all four groups of informants. A summary of reported needs in order of priority follows:

Representatives from Agencies

1. Primary prevention/education
2.5 Service provider coordination
2.5 Outreach to people where they are (homebound, including terminally ill)
4. Public relations
5. Crisis intervention services

Representatives from the Minority Community

1. Public information and education
2. Need for persons to identify with, e.g., black male counselors for black men
3. Transportation
4. Mental health outreach to community centers
5. Followup on patients after treatment

Representatives from Industry

1. Public information and and education ("crash course" for recognizing mental health problems)
2. Reaching specific industrial organizations, e.g., personnel/nurses
3. Mental health field's knowledge of industry
4. Schools
5. Programs for abused spouses/children and abusers

Patients

1. Stigma with mental health services; better public relations to reduce stigma
2. Change name of center
3. More programs dealing with stress
4. Better community education programs
5. More funding instead of less for mental health services

RECOMMENDATIONS

After reporting the findings of the needs assessment to the executive committee, the evaluation committee made its recommendations.

In view of the progress in the area of consultation and education (C&E) that had been made under the leadership of the part-time coordinator of C&E, the evaluation committee suggested that the coordinating position be made full-time. When the issue was finally resolved, this person continued as a halftime coordinator and another worker was assigned halftime to consultation and education to work primarily with industry.

STEPS TO ENSURE IMPLEMENTATION

With the presentation of recommendations to the executive committee of the Spartanburg Area Mental Health Center, the formal authority of the evaluation committee ended. The information gathered in the four workshops was, however, further disseminated. All of our informants received a report on the results of the needs assessment. The results were reported at a meeting of the clinical staff of the center and summaries were posted on bulletin boards at the county courthouse, city hall, the county health department, the county library, and the mental health center. The information was also disseminated by two members of the evaluation committee who were also members of the executive committee.

EXTENT OF IMPLEMENTATION

Because the data pointed so clearly in a single direction, we were able to make a single recommendation that was implemented in modified form. We asked for a full-time coordinator of consultation and education and got two halftime people. During the year of this evaluation, the number of persons reached by consultation and education rose from approximately 10,000 to well over 50,000.

SPECIAL BARRIERS OR SUPPORTS

The major constraint placed upon the PEC was a limitation in personnel resources. All five members of the committee had full-time responsibility for clinical and administrative activity at the center. As a result, the work of the committee was an additional activity that placed an extra burden on each member.

The principal support for the project was the autonomy given to the committee by the center director. Staff members were generous with their time in assisting with the workshop and secretarial support was available for the varied clerical tasks that were required.

Although several strategies were used to get potential participants to come to the workshops, not everybody who was invited came. We do not know how much information we missed as a result of this. On the other hand, the Nominal Group Method did insure that all who participated had their opinions and priorities recognized. As a result, morale at all of the workshops was exceptionally high.

RESOURCES AND COSTS

It is estimated that the total expenditure of time, from conception through report preparation, amounted to approximately 30 workdays. Based on the mean salary of all individuals involved, the personnel costs were approximately $1500. Supplies and refreshments cost approximately $100. Not included in any of these estimates are overhead costs for the facility.

ADDITIONAL COMMENTS

In general, we are satisfied with the way this needs assessment was conducted. Since the Nominal Group Method enables one to get ideas and facts from all informants both in the initial expression of their opinions and in the ordering of priorities, it is uniquely valuable to the sponsoring organizations and to the participants.

48. Citizen Review Group Assessment of "No Show" Rates at a New Hampshire CMHC

Kate F. Hays and Barbara W. Whetstone

Central New Hampshire Community Mental Health Services, Inc.

SUMMARY

A citizen group that included former mental health center clients was formed by the board of directors of the Central New Hampshire Community Mental Health Services, Inc. (CNHCMHS). The group reviewed an evaluation that staff had made regarding clients who do not appear for their initial appointment. The group formulated a list of recommendations to decrease the "no show" rate. The recommendations were presented to the board of directors, and the board in turn requested comments and compliance by the agency staff.

TYPE OF ORGANIZATION

A citizen review group (CRG) composed of catchment area residents was formed to conduct a review of one of Central New Hampshire Community Mental Health Services' annual program evaluations and to make recommendations to the board of directors and staff. The board of directors authorized and selected a program evaluation to be reviewed, and appointed two board members to form the citizen review group.

EVALUATORS OR MONITORS

The citizen review group was composed of eight citizens from the catchment area (2 male, 6 female) who had been previous clients of CNHCMHS. Assistance was provided by two board members and two staff members (the center's program evaluation consultant and the program director for the program being reviewed). Occupations represented on the CRG were: secretary, city planner, engineer, teacher, student, and parents.

REASONS FOR THE EVALUATION OR MONITORING

The Federal government mandated that mental health centers conduct some form of citizen review of the center's evaluation as a requirement for Federal funding. The particular program evaluation reviewed was selected by the board of directors because it was considered to be a study worthy of review, having implications relating to community acceptance and revenue generation.

LEVEL OF PARTICIPATION

The eight citizens conducted the review and formulated the list of recommendations. The board members and one staff member met with the citizen review group. They provided guidance and any information needed to accomplish the task. They also assisted in compiling recommendations. The other staff member was responsible for selecting and contacting members of the CRG, and describing the project to the them.

TARGET OF EVALUATION OR MONITORING

The program evaluation reviewed was a study of the "no show" rate at the adult outpatient service (AOPS) at CNHCMHS. The adult outpatient service is located in Concord and serves adults from the Concord catchment area. CNHCMHS as a whole served approximately 4,300 people during the year of the review. Of all the clients seen 65 percent had an income of $10,000 a year or less. Fewer than 25 percent of the clients had a history of prior hospitalization. CNHCMHS provides inpatient, outpatient, partial hospitalization, emergency, drug and alcohol, consultation and education and supportive services. These programs serve people of all ages, in one urban central office and three rural branch offices.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

A review was conducted of the AOPS study of clients who did not show up for their first appointments. The citizen review group focused on the intake procedure used with new clients.

TECHNIQUES USED

The primary review method was the Delbecq Nominal Group Method. CRG members were given copies of the study to be reviewed and sufficient information to place the evaluation in the context of the center's entire functioning. A list of

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recommendations made by CRG members was discussed and then voted on. The recommendations receiving the highest number of weighted votes were expanded to narrative form. A letter of recommendations was then sent to the board of directors.

FINDINGS OF EVALUATION OR MONITORING

In response to the center's concern about the rate of "no shows" at intake, CRG members focused their attention on the interaction between the potential client and the initial telephone contact with the center prior to intake.

RECOMMENDATIONS

The CRG made a number of recommendations. These included:

- Potential clients should speak initially with a trained intake worker.
- The intake worker should take the initiative in offering information and reassurance.
- Background information (such as a brochure) should be available to send to clients.
- A followup call to the client should be made.
- The best "match" between client and therapist should be arranged.
- Training and a "refresher" course should be developed for intake workers.

The CRG sent these recommendations to the board of directors.

STEPS TO ENSURE IMPLEMENTATION

The CRG recommendations were made to the board with the explicit expectation that there would be a written response from the board within 6 months, and that the CRG would reconvene for a final session to review the board's response to the recommendations. This, in fact, is what happened.

EXTENT OF IMPLEMENTATION

The board sent the CRG's recommendations to all programs within the agency. It found that most programs were already complying with the recommendations. In particular, a system utilizing trained intake workers had been operational since the time of the study, and intake workers were taking the initiative with regard to reassurance and sharing information. The recommendation for an agency-wide brochure gave additional impetus to an activity that had already been initiated. As followup calls had been found to have little impact on the "no show" rate, this recommendation was not implemented. Staff development plans for the next year included specific training and refresher courses for intake workers throughout the agency.

SPECIAL BARRIERS OR SUPPORTS

The major difficulty in recruiting CRG members was getting enough names of former clients, and then getting a sufficient number of people to agree to participate. In addition, there was some attrition of group members during the course of the project. This was in marked contrast to other times when CRG's composed of "key informants" have been recruited. In those instances, recruiting had not been a problem.

Primary supports for the project were an atmosphere of openness, curiosity, and acceptance on the part of board and staff; CRG member enthusiasm for the process and appreciation of the request to be involved; and an especially effective method (the Delbecq technique) of generating ideas from a number of people.

RESOURCES AND COSTS

Resources committed to the study were approximately:

- Staff--evaluator and program director, 15 hours clerical, 5 hours
- Board--2 board members, 10 hours each
- CRG--8 members, 6 hours each
- Other Costs--writing board, file cards, pens, paper, refreshments

ADDITIONAL COMMENTS

The citizen review of the program evaluation process had a number of beneficial effects. The process of program evaluation was more credible because of the board's active involvement in the CRG throughout the project. In addition, the attention paid by the CRG to "no shows" and the initial intake process increased staff interest in decreasing the "no show" rate.

49. Citizen Evaluation Using Program Analysis of Service Systems (PASS)

Rick Kastner and Marilyn Lee Olds

Lancaster County Mental Health/Mental Retardation Drugs/Alcohol

SUMMARY

In 1972, the program evaluation committee (PEC), a volunteer citizen group that is a committee of the Lancaster County (Pennsylvania) MentalHealth/Mental Retardation Board, was designated to work directly with the division of operations research to establish a procedure for review, comment, approval, and policy recommendations concerning all evaluations completed within the MH/MR system. In fulfilling this responsibility, the committee adopted Program Analysis of Service System (PASS) (Wolfensberger and Glenn 1975) as one instrument for program evaluation to be used in the community for a 3-year period. By this action, the program evaluation committee (PEC) equated program quality with integration of the normalization principle. This is consistent with the goals and philosophy of the Lancaster County MH/MR program. PASS is a standardized evaluation tool of fifty ratings that evaluates a program, its administration, quality of the environment, and the degree to which the program integrates the clients within the community. In 1981, the program evaluation committee adopted the short form of PASS, an 18-item evaluation tool, instead of the longer and more cumbersome 50-item form of PASS. This evaluation instrument is used to assess programs such as outpatient services, inpatient services, residential facilities, crisis intervention, case management services, day treatment facilities, and vocational rehabilitation.

TYPE OF ORGANIZATION

The MH/MR board is composed of citizens and includes representatives from the medical field, social work, nursing, education, religion, business, and one county commissioner. The county commissioners make the final appointments to the board upon the recommendation of the board's nomination and personnel committee. The program evaluation committee, which oversees the evaluation process, is also composed of citizens who are recruited throughout the county. The duties of the MH/MR board include reviewing the performance of programs within the system, and development of policies and procedures to govern the programs.

EVALUATORS OR MONITORS

Each PASS team consists of three to six persons including a team leader. All are trained citizen volunteers who have gone through 12 hours of instruction in order to learn how to use the evaluation tool. These volunteers include MH/MR consumers, business and industry representatives, persons with financial backgrounds, students, providers of services, representatives of advocacy organizations, and general citizenry. MH/MR board members are also encouraged to participate in the evaluation, but no team members may be paid employees of the programs evaluated.

REASONS FOR THE EVALUATION OR MONITORING

The county mental health and mental retardation regulations specify that at least three services must be evaluated each year. The law does not specify what type of an evaluation should be conducted. The board felt that citizen evaluation teams would be the most objective way of conducting evaluations on programs throughout the county. The evaluation also provides a means of citizen identification with the county programs.

LEVEL OF PARTICIPATION

Each fiscal year the program evaluation committee selects at least three types of services provided within Lancaster County to be evaluated. Immediate notification is sent to all facilities selected by the citizen committee. These providers also receive an explanation of the PASS evaluation tool and a detailed document explaining the evaluation process. The planner-evaluator, who is a staff member of the division of operations research, coordinates the evaluation process but does not take part in the evaluation itself. The citizen team is involved in the evaluation from the training workshop to the submission of the report to the MH/MR board.

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TARGET OF EVALUATION OR MONITORING

In 1982, nine programs were evaluated. They included: one private outpatient facility; one mental health community rehabilitation program; a detoxification unit; the administrative office of MH/MR; day treatment (MH) program; one drug and alcohol residential treatment facility; the drug and alcohol administration; an early intervention program for mentally retarded children; and the consultation and education division of MH/MR.

Lancaster County includes two catchment areas with a combined population of 362,000 people. It is known for its wealth of human service providers. All programs that were evaluated receive some funding from MH/MR, although funding can range from several hundred to hundreds of thousands of dollars.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The PASS evaluation tool examines program administration, fiscal matters, programmatic issues, and the physical and social environments. This includes the quality, accessibility, and availability of the service. There have been occasions when the evaluation team used the *FUNDET* evaluation tool. *FUNDET* looks primarily at fiscal concerns in relationship to the needs of special groups such as blacks, children and youth, low-income people, Hispanics, and geographically isolated persons.

TECHNIQUES USED

After the PEC selects the agency and the agency is notified, the team meets to review the evaluation tool and also to review factual information about the site that is provided by the agency as part of a 20-page questionnaire. Following the information review, the team makes a site visit. The site visit team spends a day and a half observing the program and interviewing staff, clients, administration, parents, board members, and support personnel. The PASS evaluation is condensed into a booklet of worksheets that the team uses throughout the site visit and during the reconciliation meetings. After the site visit, the team meets for two or three meetings to reconcile each of the ratings in PASS. Observations are made, and commendations and recommendations are then developed and placed in a report.

FINDINGS OF EVALUATION OR MONITORING

In 1982, all programs were found to be providing adequate service, and in many cases, the service was found to be exceptional. Site visit teams felt that improvement could be made in areas such as case records, beautification of the environment, additional space and facilities, and changes in fiscal reporting.

RECOMMENDATIONS

The team addresses each finding with either a recommendation or a commendation. Issues are highlighted by the team when additional concern should be focused upon particular recommendations. Recommendations are directed at the program itself, the director, the MH/MR system, and also the MH/MR board. All commendations and recommendations are sent to the agency board, the director and staff, the PEC, and ultimately, the MH/MR board. The evaluation team and the agency staff meet to clarify the report and discuss the findings.

STEPS TO ENSURE IMPLEMENTATION

After the team finalizes the report, it is sent to the program evaluation committee and a meeting is held between the PEC and the agency to clarify the report. The PEC then develops a short report to the board that is submitted with the team's evaluation. These are reviewed by the MH/MR board. The agency once again is invited to an MH/MR board meeting, at which time the report is reviewed and recommendations made. The PEC report of the evaluation, with a written response from the agency, is then published in a public document and sent to the State offices of mental health and mental retardation, public libraries, the county commissioners, local college libraries, advocate groups such as the Lancaster Association of Retarded Citizens (LARC), the Mental Health Association, agencies throughout the county, and citizens who participated in the evaluation. The agency also must provide a written plan of action within 90 days of the MH/MR board's review of the evaluation. This action plan must state how the agency is to implement each of the recommendations. Not all recommendations have to be carried out, but an explanation of why they are not carried out must be included in the report. The program specialists for mental health and mental retardation then monitor the implementation of these recommendations throughout the year. Agencies may be placed on probation or contracts terminated if the evaluation team and the PEC believe that the program does not measure up to its contract.

EXTENT OF IMPLEMENTATION

Most agencies that are evaluated do implement the recommendations. However, those recommendations requiring large amounts of money or that are viewed as inappropriate may not be implemented. Reasons for noncompliance must be presented in the action plan submitted to the

board. For example, some agencies were requested to look into the possibility of moving their facilities to areas that were more accessible to the client population. Since this recommendation would be extremely costly, the programs decided not to move but will take the recommendation into consideration if and when funds are available. Recommendations that have been implemented in many of the programs include changes in accounting procedures, beautification of the property, programmatic changes such as using generic resources throughout the community, and many other changes that do not require large sums of money.

SPECIAL BARRIERS OR SUPPORTS

Although it is cost effective to use volunteers and information from the community is very helpful, there have been problems with volunteers dropping out of the evaluation. This may leave the team with an insufficient number of evaluators. The time that each evaluator must contribute to the process includes 1¾ days during the week to visit the site and approximately 20-30 additional hours to prepare the reconciliation and final report. Another problem is that some evaluators find it difficult to limit themselves to the evaluation tool and the team may find itself bogged down in extraneous topics. Using one standardized evaluation tool for all programs or agencies is sometimes a problem. The evaluation tool is not appropriate for all programs, although we find it does relate in many ways to most programs being evaluated. When a rating does not apply to a particular program, the team has the option of stating this in the report and skipping that particular rating.

Support for this evaluation process includes suggestions from the community for programs for which the community ultimately pays. The general public is also educated throughout the evaluation process. This produces citizen advocates who are useful in other areas of the program and who would support the program financially and politically. The evaluation process has proved effective over the last 10 years. The MH/MR board has become more familiar with this rather large and complex system after they have reviewed the evaluations, and the county has gained a pool of dedicated and trained volunteers.

RESOURCES AND COSTS

Cost studies are currently being compiled, so no bottom line figure can be placed on the evaluation process at this time. The evaluations require a part-time secretary and a part-time evaluation coordinator who brings together the entire evaluation process. Duplication of the reports and support materials is another cost factor that must be considered. Using citizen volunteers cuts down on the cost of the evaluation, but there are overhead costs, such as food, gas, reproduction of materials, cost of a recognition night for the citizens who volunteered their time. There is also the time and money spent by the evaluated agency to produce the documentation needed and the time spent during the interview/site visits. Nevertheless, when compared to the purchase of professional evaluators' time, citizen evaluation is cost effective.

ADDITIONAL COMMENTS

The PASS evaluations have been implemented for the past 10 years in Lancaster County and the office of MH/MR plans to continue using the instrument. The short form of PASS is currently being used. This reduces time and money spent on each evaluation. Other evaluation mechanisms are also being planned and implemented within Lancaster County in addition to the PASS citizen evaluations.

50. An Agency Board Moves Toward Client Outcome Evaluation

Vera Mellen

The Social Center, Fairfax, Virginia

SUMMARY

Several years ago, the research and evaluation committee of the board of directors of The Social Center made an organized effort to obtain the data necessary to provide a basis for evaluating the center's effectiveness by tracking client outcomes. The initial data collection was accomplished in 6 months and led to important changes in the recordkeeping of the agency. The larger goal of assessing client outcomes proved an ambitious aim and took much longer to implement.

TYPE OF ORGANIZATION

The Social Center is operated by a board of directors consisting of 20-25 citizens from the community. The board employs an executive director and a staff of 30 who serve 400 clients

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per year. Board members are elected by the board upon presentation by the nominating committee. Every effort is made to make membership as representative of the community as possible.

EVALUATORS OR MONITORS

The research and evaluation committee of The Social Center's board of directors consists of individual board members who are lay people, although many have professional backgrounds in psychology, social work, or related disciplines. The membership on this committee has varied considerably over the several years during which this and related projects have operated.

REASONS FOR THE EVALUATION OR MONITORING

The lack of staff time to collect, organize, interpret, and utilize data was the primary stimulus for the initiation of the evaluation efforts on the part of the board.

LEVEL OF PARTICIPATION

The referral study was strictly an internal project. The evaluation committee reviewed referral data routinely collected by the center. This data had never been systematically analyzed by center staff, so it was up to committee members to determine what pieces of information were important for an evaluation and to design an analysis plan.

TARGET OF EVALUATION OR MONITORING

The Social Center is a private, nonprofit corporation which provides rehabilitation for adults with chronically severe emotional disorders. It has two locations in the Virginia suburbs of Washington, D.C., although at the time of this study the agency had three locations.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

The evaluation committee determined that followup studies of client outcome could not take place until more fundamental data were collected. For instance, which agencies in the community were making referrals? Were they appropriate referrals? It was also important to find out who was attending the center (i.e., what was the distribution of age, sex, race, etc.). Information regarding such factors as diagnosis and prognosis was also necessary. A long list of data obtainable from the agency referral form was collected and evaluated. The long-range goal was to track client outcome and agency effectiveness.

TECHNIQUES USED

Agency referral forms for a specific fiscal year period were collected. All forms were examined by evaluation committee members and data from these forms were organized and a report was prepared. An important step was taken at this time. The agency's intake form was expanded to include a permission slip from every incoming client which would allow him/her to be interviewed by a member of the evaluation committee after he/she left the center program. This allowed the committee, over a period of years, to assemble a large body of data from which to organize other studies. The committee members were trained by staff to ensure protection of the confidentiality of the clients.

FINDINGS OF EVALUATION OR MONITORING

The referral study provided data on: numbers of clients, sex, employment status, diagnosis, appropriateness of referral, and percentage of referrals in which actual service was initiated. In addition, data among center locations were compared and contrasted. This information was critical in order for the committee to understand who was attending the center. Additionally, it provided the beginning of a database which was added to yearly. This result was probably the single most significant outcome of the study.

RECOMMENDATIONS

Since this effort was not a real evaluation study but a collection of data, the results did not change the program per se. It did, however, add much to the understanding of staff regarding the flow of clients through the center. This in turn improved the basis upon which budget requests were made, etc. It also allowed for helpful comparisons among center locations, which gave rise to examinations of particularly successful programs in one location and attempts to replicate them throughout the social center sites. In this sense, the study provided an interesting evaluation tool. No actual recommendations were made except to redesign the intake form to allow followup studies of clients.

STEPS TO ENSURE IMPLEMENTATION

The above recommendation was implemented by having a staff committee redo intake forms.

EXTENT OF IMPLEMENTATION

The data accumulated as a result of the above recommendations was later compiled into a computerized data study under the direction of the research and evaluation committee of the board. Computer time was donated by a local university and the board of the social center paid

for the time of a programmer to code and program. As a result, the database was very much improved and expanded and now the center's data can be compared to national figures on the chronically mentally ill population.

SPECIAL BARRIERS OR SUPPORTS

The original goal proved very ambitious for a volunteer board. It has taken years to accomplish what originally was expected to take one or two. The lack of staff time also was a problem. Had more staff time been available, the study would no doubt have taken less time. The commitment of individuals who chaired the research and evaluation committee seemed to make a significant difference regarding how much was actually accomplished over a given period.

RESOURCES AND COSTS

Accurate records of individual time given were not kept. The referral study itself was accomplished in approximately 6 months.

ADDITIONAL COMMENTS

Though the study took much longer than was originally expected, the center expects to have an excellent foundation for program design and for the outcome studies that were the original goal of the committee.

51. Citizens Use the Freedom of Information Act

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University of Missouri

Michael J. Walters

Sister of Charity Hospitals, Cincinnati, Ohio

SUMMARY

This project began as an attempt to evaluate followup services for adult patients discharged into the Mid-Missouri mental health center (MMMHC) catchment area. The study was conducted by the Mid-Missouri Citizen Evaluation Team (MCET). During the early stages of the study, the MCET was blocked by its efforts to obtain: (1) copies of the Mid-Missouri mental health center survey forms, used by the biometry division of the National Institute of Mental Health (NIMH); and (2) copies of Region VII Mental Health Administration's site evaluation reports on the mental health center. Both documents were considered crucial for a comprehensive evaluation of outreach services. This case describes and analyzes the process by which the MCET met the resistance of the Region VII office from the beginning of the conflict through the achievement of a formal amendment to the Public Information Regulation (*Federal Register*, Subpart F, Section 5.72(d), August 17, 1973). It also describes the evaluation of outreach services.

TYPE OF ORGANIZATION

MCET members were recruited from a group of citizens voluntarily involved in mental health services in the Mid-Missouri region. MCET was not officially a part of the county association for mental health nor was it part of the citizen advisory board of the Mid-Missouri mental health center, although MCET members had a working relationship with these mental health agencies. Funding for MCET activities came from a small NIMH grant. The purpose of the grant was to assess the effectiveness of citizen evaluation. Team members received a $10 stipend and travel reimbursement for each meeting attended. The remaining money was available for research costs. Approximately 30 regular meetings were held with many special sessions over a 12-month period. A final report was written and published by the team members.

EVALUATORS OR MONITORS

Seven persons made up the team. Their ages ranged from the early twenties to late sixties. Of the four men and three women, five were college graduates and four had obtained masters degrees. Three members were fully employed outside the home, two were homemakers, one member was retired, and one member, employed intermittently, left the team because of a recurring illness. Richard Hessler and Michael Walters served the dual roles of consultants and facilitators to the team plus evaluation researchers whose goal it was to describe the effectiveness of citizen-controlled evaluation research. As researchers, Hessler and Walters recorded all meetings, catalogued extensive field notes,

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memos, letters, and published two papers in professional journals.

REASONS FOR THE EVALUATION OR MONITORING

The MCET members decided at their first meeting to explore followup services as a likely focus for a research problem. In order to determine if this was an issue worth pursuing, the members opted for a site visit to the MMMHC. Existing evaluation data were sought as background reading in preparing for the site visit. At the time this decision was made, only one MCET member knew of the existence of site evaluation reports but that knowledge was all it took to focus the data search on those reports. A quick check uncovered the facts that (1) a recent site evaluation report was done on MMMHC; (2) the NIMH Federal office had copies of the reports but preferred that MCET go to the regional office for copies that it had on file; and (3) the Missouri State division of mental health also had copies.

The MCET members viewed the site evaluation reports as crucial for defining the research problem and they perceived their request as a test of citizens' access to data. The access issue was tied to the dual goals of MCET's substantive research and of testing the citizen's right to use the evaluative data. The MCET request for copies of the report was denied by the regional office and a struggle ensued.

LEVEL OF PARTICIPATION

The MCET set as its research goal the evaluation of followup services for adult mental patients discharged into the Mid-Missouri mental health center catchment area. As such, the MCET members had full control over all research design decisions, including the very definition of the research problem and the writing of the final report. It was the team's decision alone to fight for access to data defined by team members to be essential.

TARGET OF EVALUATION OR MONITORING

The Mid-Missouri mental health center is located in a rural area, near Tipton, Missouri. This study focused on outreach services to clients residing in MMMHC's catchment area.

PROBLEMS OR ISSUES EVALUATED OR MONITORED

Originally, the target of evaluation was followup services provided to adult patients discharged to the catchment area served by the Mid-Missouri mental health center. When team members were unable to obtain copies of NIMH site visit reports, the focus quickly changed to an attempt by private citizens to gain access to evaluation information compiled on a publicly funded agency.

The MCET and NIMH represent two institutional viewpoints in conflict over interpretations of their respective mandates or claims. The NIMH regional office defined access to biometry data as limited only to "professionals" whereas the MCET members thought that this was elitist. Neither side could see any merit in the other's claim and an impasse was reached very quickly.

The beginning of the conflict had distinct and very different features than its later phases. At first, the MCET members were unsure of who was accountable for the decision to bar access to the site visit documents. They had a limited understanding of the substantive worth of the forbidden data, and they were reluctant to firmly insist that the data be made available for fear of jeopardizing the research itself. Similarly, the other side was uncertain about the competence and tenacity of the MCET members, the legitimacy of the proposed research, and their own legal position. MCET was committed to defining the research problem and the site evaluation data were viewed as an indispensable aid. The NIMH regional office was equally committed to keeping the site evaluation data out of the MCET members' hands.

TECHNIQUES USED

MCET's strategy was based on a desire to avoid contaminating the research on followup services. The team members felt that pressure placed on the center's administration would have negative consequences in terms of gaining cooperation from the center staff to do interviews concerning followup services. From the MCET perspective, it was more desirable to confront the State division of mental health and the regional office of NIMH than it would have been to fight the battle closer to home.

The NIMH regional office staff also wanted to keep things under control, and attempted to constrain MCET members in their efforts to obtain the necessary documents. The strategy involved, (1) informing MCET that the State division of mental health (grantee for MMMHC) was the appropriate source for procuring the site evaluation report; and (2) claiming that they had been advised by the NIMH Federal office not to release site evaluation reports because they were exempt from disclosure under section 5.75 and example 4 of appendix A of the Public Information Act. Thus, the NIMH regional office staff sought to redirect MCET's challenge by claiming powerlessness to act and by passing the buck to another institution. The outcome was that neither the Federal nor the regional office produced the evaluation report.

The MCET compiled and sent a letter to the

State mental health office. Once again, MCET's legitimacy was questioned as part of the reason for rejecting the request. The MCET members decided to meet with the State director and to proclaim their legitimate role as researchers. Simultaneously, MCET members requested a meeting with regional office administrators for the same reason.

A phone call to the regional office to set up the proposed meeting led to the following: (1) regional office administrators did not want to meet with MCET members; (2) a regional office lawyer added a legal dimension to the refusal based on section 5.75 and example 4 of appendix A, Public Information Act; and (3) regional office administrators reiterated that it was "the responsibility of the Federal office of NIMH to supply you with the needed data." The reasoning here was that since NIMH funded MCET, NIMH should provide the needed data. Two days later, another phone call, this time from the administrator at the NIMH regional office, added the following boundaries to the refusal: (1) Citizen evaluators did not have a legitimate role to play in (a) evaluating a center's compliance with the terms of a contract or (b) in developing policy through research; (2) Citizens should assist the regional office in developing services at centers--period; (3) MCET should try to negotiate an "exception to the law" by contacting the chief of the legislative services branch, NIMH, and HEW Assistant Secretary of Public Affairs. The site evaluation report had become an end unto itself, a symbol of power and control for both sides, the perceived importance of which far exceeded its potential substantive utility.

The MCET members wrote a letter to the chief of the NIMH legislative services branch describing the status of the refusal. Simultaneously, the MCET project officer at NIMH was phoned and he informed the MCET that the regional office administrator had asked him to intercede. The project officer told MCET that he refused. Furthermore, he offered to get an endorsement for MCET from the section on citizen participation of the American Psychological Association.

The pathway to a legal resolution was now in place. The MCET chairman wrote a letter to the assistant chief of the legislative services branch, NIMH, laying out all that had transpired and asked for a formal, precedent-setting amendment to the Public Information Act that would enable citizen groups to gain access to site evaluations of mental health centers. The assistant chief wrote back to inform the MCET members that he had directed the HEW Freedom of Information officer to rule on MCET's case.

Slightly less than 1 month after the MCET chairman wrote asking for an amendment to the Public Information Act, the assistant chief of the legislative services branch responded to the MCET chairman informing him that the regional office must release the reports to the MCET. More importantly, his ruling reflected a new amendment to the Public Information Act. This new amendment guaranteed MCET, as well as other citizen groups, access to these and similar reports.

Once the MCET members obtained the reports needed, they moved on to the evaluation of outreach services using the NIMH reports for background. The evaluation of outreach services included interviews with the mental health center director, staff of the outreach service, staff in the NIMH regional office, the Missouri director of mental health, and staff from other social service agencies who might have contact with clients in the community.

FINDINGS OF EVALUATION OR MONITORING

Once the data were reviewed, the MCET members concluded that outreach services were fragmented and that many clients were "falling between the cracks." Followup services were frequently deficient and many clients were floundering in the community.

RECOMMENDATIONS

The MCET recommended that followup services needed to be improved and that a system for keeping track of clients in the community should be implemented.

STEPS TO ENSURE IMPLEMENTATION

The MCET members presented their findings to the center and used the report to gain community support for the development of a halfway house for women who were being dischaged from the hospital.

EXTENT OF IMPLEMENTATION

With the exception of the halfway house, the MCET's recommendations were not implemented because funding was not available.

SPECIAL BARRIERS OR SUPPORTS

The major barrier in conducting this study was the resistance that MCET members encountered in their attempts to gain access to reports. The major support was the perseverance of the team members.

RESOURCES AND COSTS

This project was funded as part of a larger NIMH team. The team's budget was approximately $4,600 and covered the cost of transportation, printing, postage, etc. Team members were also paid a small honorarium for attending meetings.

ADDITIONAL COMMENTS

The MCET victory was the outcome of a protracted struggle between two institutions vying for legitimate control over evaluation data. The NIMH regional office sought to protect its claim of professional competence by defining the citizen evaluators as imposters, as perpetrators of the erroneous idea that individuals other than mental health professionals can manage the analysis of complex evaluation data, including the protection of respondents' anonymity and other commitments made by the professionals. The MCET members used the site evaluation data as a symbol of their legitimate role as researchers. By achieving possession of the data, the claim to professional competence was established along with the legal mandate that institutionalized the legitimacy of the citizen evaluation research role.

The MCET case heralded a genuine shift in power, not some ritualized demonstration project. The precedent for future citizen evaluative efforts was set, the knowledge of "how to do it" was documented, and the mental health discipline awaits other efforts of citizens to improve services through research.

How Will the Results Be Used?

Doug Brown and his evaluation committee reviewed available county and State data and conducted interviews with administrators from the department of mental health and mental retardation, officials from Riverview State Hospital, and providers from the community service system. After analyzing and synthesizing the information, the committee compiled a draft report. The draft was submitted to the mental health association, the county and State mental health departments, Riverview administrators, and the community providers who had been interviewed. The comments provided by all parties were reviewed and, where appropriate, changes were made to the final version of the report.

Two major findings emerged from the study. One was that there appeared to be a history of poor communication between the county department of mental health and Riverview State Hospital. The committee members feared that this poor communication could jeopardize the orderly movement of clients from the institution to the community. Secondly, the committee found that the community was ill prepared for any large deinstitutionalization. They found inadequacies in community services for the elderly, in housing, and in aftercare programs.

Based on these findings the committee made two recommendations. First, they suggested that one person at the county department of mental health and one person at Riverview should be appointed as liaison persons to oversee the process of closing the Riverview wing and to ensure adequate communication. Secondly, the committee recommended that clients from the unit should be discharged in stages over a 2-year period so that the community service system would have time to gear up to provide an adequate level of service.

The committee felt strongly about the importance of these recommendations. They therefore spent considerable time on their strategy to ensure that the recommendations would be implemented. Their first step was to debrief the State and county officials of the departments of mental health. They communicated their findings, voiced their concerns, and attempted to get a commitment from their departments. Secondly, they contacted their local State representative and communicated the findings of the study to her. She arranged for Doug Brown, as the committee chairman, to make a presentation before the legislative budget committee. Finally, the committee wrote a press release, and the study's findings and recommendations were disseminated through the local media.

This chapter describes some of the techniques that citizen evaluators can use to ensure the visibility of evaluation and monitoring results and the ultimate implementation of recommendations. The failure to give adequate consideration to a strategy for disseminating study results and for maximizing the chances that recommendations will be implemented is a serious shortcoming of many evaluation studies conducted by professional as well as citizen evaluators. In conducting assessments of services, evaluators are often strongly tempted to focus too much energy on the process of the study itself. No matter how well the evaluation process is carried out, it is unlikely that the study will have its intended effect without a proportional expenditure of effort on dissemination.

Decisions about possible implementation strategies are constrained to some extent by the group's position or its relationship to the mental health system. In some cases, groups have formal authority and can demand that their recommendations be implemented. Other groups have to be more creative to make their points. In this

chapter, we summarize some of the strategies that groups might use by referring back to cases discussed in the preceding chapters.

Agency Debriefing

Three cases illustrate the use of agency debriefings. Agency debriefing means simply that the evaluators or monitors communicate their findings and recommendations directly to the agency or agencies evaluated or monitored. This is nearly always good practice. In the first place, agency staff frequently are in the best position to implement study recommendations. Secondly, it is bad politics to pass study results on to county or State officials without notifying the agencies and giving them the opportunity to respond.

One example of this approach is described in case #45 by Aldene Hart and Barbara Goza (Citizens' Advisory Council Uses Case Simulation Technique to Evaluation Crisis Services). In this case, a citizens' advisory council evaluated the quality and accessibility of a CMHC's crisis services. After completing the study, citizens presented the study findings to the CMHC staff and commended them for the high-quality service they were providing. Giving agencies this type of positive feedback is a useful way of enhancing the relationship between the citizen group and local service providers.

Another example of agency debriefings is described in case #49 by Rick Kastner and Marilyn Lee Olds (Citizen Evaluation Using Program Analysis of Service Systems). In this case, the researchers met with staff from the various agencies evaluated to review the study findings. After the agency had the opportunity to respond, the report was forwarded to the county mental health and mental retardation board. Agency staff were invited to attend the board meetings at which the report was discussed.

A third example, case #20, (Council for Community Services Agency Evaluation) by Beverly Kries et al., describes how evaluators can involve agency staff throughout the entire evaluation process. The task force conducting the evaluation provided feedback and technical assistance as issues emerged during the evaluation process. As a result, the authors report, many of the study's recommendations had already been implemented by the time the evaluation was completed.

Inclusion in an Annual Plan

Frequently, boards have the authority to incorporate their recommendations into the annual plan of an agency, a county, or a State. This is a useful implementation strategy since it establishes a benchmark against which the next year's performance can be measured. Several of the previous cases exemplify this type of implementation strategy.

The authors of two cases describe agency boards that have used this strategy. Roger Strauss (case #7, Mental Health Center Board Increases Involvement in Evaluation of Center Needs) describes a needs assessment conducted by a center board in Vermont, and Donald Eib (case #11, Citizens as Subjects of Evaluation) describes a project involving the development of a model for long-range planning. In both cases, the recommendations resulting from the studies were incorporated into the agency's annual plan.

At the county level, Jean Fiore (case #16, County Board Assists in Assessing Local Services) describes a county board's evaluation of emergency services. In order to ensure that their recommendations were addressed, the board's study committee disseminated its final report to the full county advisory board, the chairperson of the county department of human services, and the State regional office. They also included their recommendations in the county plan.

Dennis Geersten (case #1, State Council Assesses Utah's Mental Health Needs) describes this same process at the same level. In this case, Utah's State planning and advisory council conducted a needs assessment of the problems of the State's special populations and their service needs. The board's recommendations were incorporated into the State's annual plan.

Securing Political Support

Another strategy that may be useful on occasion is enlisting the support of State legislators. Jan Holcomb et al., in case #30, describe how a mental health association cultivated relationships with legislators and their staff. This is a useful technique that brings necessary information to the groups that control the allocation of resources. This case report describes how association members assisted State legislators in developing an agenda for public hearings on appropriations for mental disabilities, offered testimony to legislative committees, and worked with their association lobbyist to introduce legislation recommending changes in the State hospital system.

Constituency Building/Information Sharing

Constituency building is another strategy that can be used to disseminate study results and gain support for recommendations. Frequently, gaining the support of other civic or community groups can increase the credibility of one's arguments. This method is illustrated in case #32, described by Frances P. Meehan (Citizens Evaluate Allocation of County Mental Health Resources). In this case, a citizen review of county data revealed that county mental health funds appeared to be distributed unevenly across different regions of the county. Members of the mental health services liaison committee presented their findings to a wide variety of civic groups in order to

gain popular support for their case. The groups included the mental health advisory board, the American Association of University Women, the League of Women Voters, the regional planning council of the United Way, and a variety of service clubs. In the end, the liaison committee was able to enlist the support of 12 community leaders who joined the committee in a joint presentation to the area's county supervisor.

Funding Sanctions

The next strategy to be discussed is the use of funding sanctions. Clearly, the threat of withholding funds cannot be used by groups whose power is limited to moral suasion or the like. However, for those groups that have some amount of authority over the funding process, this is a powerful tool indeed. In case #3, Jessica Wolf describes an evaluation of an agency halfway house and supervised apartment program. Connecticut law requires that agencies be evaluated by regional mental health boards. These boards have the authority to either approve or disapprove continued funding of mental health programs. In this case, the initial recommendation to the regional board was to terminate funding for the apartment program because of low occupancy rates. After reviewing additional data suggesting an improved occupancy rate, the board recommended conditional funding.

Diane Rich (case #15, Citizen Participation in Federal-State Site Visits) describes how a mental health association's recommendations were included in Federal reports that ultimately affected whether agencies received continued funding. Similar sanctions are described in case #44 by Frances P. Meehan and John J. McDonough (A Mental Health Advisory Board's Use of Secondary Data Analysis Techniques) and in case #49 by Rick Kastner and Marilyn Lee Olds (Citizen Evaluation Using Program Analysis of Services Systems).

Use of the Media

For those groups that do not have authority over funding, an alternative strategy might be to bring the case to the media. This strategy was utilized quite effectively by members of the Mental Health Association of Greater Chicago (Jan Holcomb et al., case #30). In this instance, members of a site-visit team suggested to reporters from the **Chicago Sun Times** that they expose some of the systemwide problems in health services. This led to a six-part newspaper series entitled "Breakdown: Mental Health in Crisis." As a result of this publicity, the Governor became involved in the issue, appointed a task force, and invited the association's participation in the mental health planning process. Barbara Geddie (case #43, Emergency Services in High Point) also describes the use of radio, television, and newspapers in a local mental health association's attempts to publicize the need for afterhours mental health emergency services.

Litigation or Other Advocacy

A very powerful implementation strategy that probably should be used only as a last resort is the use of the courts. Darlene Humphrey (case #5, External Group Advocates for Better Care) describes the efforts of Consumer Advocates for Better Care (CABC) to improve conditions in nursing homes. CABC monitors nursing homes through site visits and informal interviews with residents. The case described by Ms. Humphrey involved a nursing home that was cited for a number of serious abuses. CABC turned its findings over to a local legal-services agency which in turn passed the information to the State attorney general's office. As a result of these actions, this particular rest home has been closed and its license suspended.

As this case illustrates, litigation is an extremely powerful strategy. However, it is time-consuming, costly, and tends to have the inevitable byproduct of polarizing both sides. If a citizen group must rely on the target of evaluation for cooperation over the long term, then some other means of dispute resolution should be attempted first.

Stacking the Board

Finally, under the heading of "If you can't lick them . . ." is the implementation strategy of placing citizen evaluators on agency boards or higher level boards to ensure a continued presence. Rita Parle (case #18) describes a community group's evaluation of a mental health center that had been the object of controversy within the community. After completing an evaluation that led to numerous recommendations, the external committee attended a number of board meetings to ensure that the concerns raised in its report were addressed. In addition, one member was appointed to the center's board of trustees and several other members joined the center's advisory board.

A variation of this is for the board to hire or recommend that the agency hire one or more individuals for the purpose of implementing the study's recommendations. This approach is illustrated in case #35 by Joyce G. Smith.

Summary

The cases presented in this *Casebook* demonstrate the inventiveness with which citizens have approached evaluation and monitoring tasks and the quality of the work that has resulted. The contributions of citizens involved in evaluation and monitoring have been significant; however, there are certain concerns and issues that should be highlighted if such involvement is to continue as a strategy for improved mental health and other human services.

On the positive side, citizen involvement in evaluation has definite advantages for the citizen group or organization, for the individual citizen, and for the agency or agencies being examined. Citizen involvement in evaluation frequently results in increased visibility and credibility for the citizen group or association. Over time, it also generates for the association a pool of individuals with the research skills necessary to conduct new studies or to review critically the reports generated by professionals within the system.

For the individual citizen, the experience also appears to have positive results. Citizens report a feeling of accomplishment once the projects are completed, and they appreciate the new skills acquired during the process. Some citizens have even expanded their own personal development by obtaining more education or moving into more visible positions in the community. The experience also provides them with increased knowledge about the local system.

From the agency's perspective, one overwhelming advantage is the economy involved in using citizens as evaluators and monitors. With increasing budget constraints, this factor assumes even greater importance. The agency also benefits from the different perspective that citizens who are not formally part of the system bring to the evaluation or monitoring process. Finally, to the extent that involvement in evaluation or monitoring imparts to citizens a sense of ownership of the program or programs, the agency also benefits from the political support that such advocates can muster.

Although citizen involvement in evaluation and monitoring has very clear advantages, there are also some drawbacks. One is that the process can at times be inefficient due to the inexperience of the individuals involved. Citizens very often require training in evaluation techniques, in the use of survey interview forms, and in the general conduct of program review activities. Secondly, citizens may have significant constraints on their time and almost always have little in the way of financial resources for projects. Moreover, volunteers may relocate or become employed, thus providing little continuity in implementing the evaluations. Also, because of their position within the system, they frequently have little authority to demand access to information and must rely on moral suasion instead.

Finally, since evaluation and monitoring have traditionally been conducted by trained professionals, agencies are frequently wary of allowing citizens who have little formal training to take over these tasks. Agencies may simply resist any review by the community, especially if program inadequacies have already been highlighted by others. Citizens, however, can minimize agency resistance by identifying key staff who are willing to cooperate with and support outside evaluators or monitors. One or more internal advocates will ease implementation of both citizen evaluation activities and the ensuing results.

These drawbacks notwithstanding, the cases described in the *Casebook* demonstrate clearly that citizen groups are capable of conducting skillful and innovative evaluation projects, and that these projects can have an impact on the mental health system.

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Glossary of Terms

Balanced service system--an accreditation scheme developed in the 1970s by the Joint Commission on the Accreditation of Hospitals to assess the quality of services delivered by CMHCs. The standards reflected both traditional and nontraditional service delivery approaches.

Barrier free--describes an environment such as a house or office building which is accessible to physically handicapped persons. For example, doorways may be widened to accommodate wheelchairs, or ramps might replace stairways.

Case management--an approach to organizing service delivery in which one individual--*a case manager*--has responsibility for coordinating all of the services required by an individual client.

Catchment area--the geographic area for which a community mental health center has responsibility. The population size of catchment areas generally ranges from 75,000 to 200,000 persons.

Cost effectiveness--maximizing the achievement of program goals (e.g., improving client outcomes) while minimizing program costs.

Cost efficiency--maximizing output (e.g., increasing the number of clients served) while minimizing the expenditure of resources.

Diagnostic Statistical Manual III (DSM III)--diagnostic code published by the American Psychiatric Association in 1981. It is a standard taxonomy of diagnoses and is used internationally.

Field test--when evaluators design a new instrument, they typically try it out on a few respondents in order to identify any problems with the instrument itself. This is also referred to as a pretest.

Halfway house--a residence designed for individuals making the transition from a hospital setting to community living.

Inservice training--seminar and workshop programs that are offered by employers. The purpose of inservice training is to help staff improve their professional skills and to keep staff informed of new developments in their fields.

Key informant--knowledgeable individuals within the community who can provide data or interpret events that are relevant to the particular project.

Needs assessment--a study that attempts to identify the service needs of populations or special subgroups. A needs assessment may also include an examination of services that are already in place and an identification of service gaps.

Nominal Group Technique--a structured group approach to problemsolving in which equal participation of all group members is solicited.

Partial hospitalization--programs designed for mentally ill clients who need more than traditional outpatient therapy but do not require inpatient hospitalization. Clients typically attend partial hospital programs for half or full day sessions during which they receive a variety of mental health, social, and vocational services. These programs are sometimes referred to as day treatment programs.

Psychosocial rehabilitation center--an agency providing traditional mental health services as well as a variety of social learning, vocational, and community living programs.

Psychotropic medications--drugs that are prescribed by physicians to control some of the symptoms of mental illness.

Reliability--the accuracy of a measure over repeated trials.

Sample--a subset of cases selected for study from a larger population. A good sample is representative of the population from which it was drawn and the sample data can, therefore, be used to describe the larger population. Sampling is used because it is frequently too costly to collect data on all relevant cases in a population.

Secondary data analysis- analyses that rely on data that have been collected for another purpose but are available and relevant to the particular study.

Transitional housing--housing programs that are designed for clients moving out of a hospital setting. These programs provide supervised living arrangements and typically offer a variety of other mental health and community support services.

Validity--the degree to which an indicator actually meaures what it is intended to measure.

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